Volume 8

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE JOSEPH C. SPERO, MAGISTRATE JUDGE

DAVID AND NATASHA WIT, et al., Plaintiffs,	)	
VS.	)	**No. C 14-2346 JCS**
UNITED BEHAVIORAL HEALTH, Defendant.	)	
	)	San Francisco, California Monday, October 30, 2017

TRANSCRIPT OF PROCEEDINGS

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I N D E X

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P R O C E E D I N G S

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THE CLERK: Okay. We are calling Case Number C 14-2346, Wit/Alexander versus UBH.

And all counsel and parties are here.

THE COURT: Okay. What's up?

MR. GOELMAN: Your Honor, I just have one matter to address before we start the evidence today. The Court's confidence in the parties' ability to work out the Shulman confidentiality issue was warranted. I want to thank the defense for taking care of that.

The bad news is that we do have an additional Shulman issue before we start today.

THE COURT: Shulman issue?

MR. GOELMAN: There's a whole genre of issues now.

THE COURT: Yes.

MR. GOELMAN: The first piece of evidence that the defendant is putting on today is going to be the deposition of Rhonda Robinson-Beale, who was at the company in 2014 and then left and was deposed in this case in 2017.

THE COURT: Okay.

MR. GOELMAN: And the Shulman report, which we have objected to and the Court has overruled, actually turns out there's more than one iteration of it.

THE COURT: Oh.

MR. GOELMAN: And the one that counsel showed to Ms. Robinson-Beale is Trial Exhibit 1033. The one that Mr. Shulman sent to UBH is Trial Exhibit 412. And they're very different. 412 has track changes that Mr. Shulman used to point out some of his objections to the guidelines; and 1033, the changes have been accepted.

So that Ms. Robinson-Beale was shown a document where she couldn't see some of the changes that Mr. Shulman made, and we have not objected on that basis up to this point and now we do.

THE COURT: Huh. On the basis of what?

MR. GOELMAN: It's misleading, Your Honor. She is shown this document three years after she left the company and told that this is Mr. Shulman's --

THE COURT: Do you think I won't be able to understand that?

MR. GOELMAN: I think she didn't understand it, Your Honor.

THE COURT: Well, as to any of it? All of it? There's no questions she was asked about the Shulman report that are about things that are relevant to the case?

MR. GOELMAN: No, no. She is asked about things that are relevant. My point just is she's shown this document three years after she left.

THE COURT: No, no, no. I appreciate that, but it's

one by one. We do questions one by one. So if you ask a question that says -- that implies that there's no changes in the language and she thinks there is a change, well, then, that's a problem. If she is asked a question where there's no changes in the language, then that's not a problem.

MR. GOELMAN: It's less the questions than the use of the document itself that we object to.

THE COURT: Okay. That's overruled. Good work.

MS. ROSS: Thank you, Your Honor. Good morning.

THE COURT: Sometimes it's the best thing to remain silent.

Okay. So what else?

MS. ROSS: We're ready to begin.

THE COURT: Okay.

(Pause in proceedings.)

THE COURT: Oh, okay. I see.

MS. ROSS: Your Honor, United Behavioral Health calls Dr. Rhonda Robinson-Beale, who's a former employee who lives out of state and will appear by video.

THE COURT: Hang on one second.

(Pause in proceedings.)

THE COURT: Okay. Ready.

(Video was played but not reported.)

MS. ROSS: One moment, Your Honor.

(Pause in proceedings.)

MS. ROSS: Your Honor, we seem to be having technical difficulties with the video. Can we read -- would we have permission to read the remainder of the transcript in? There's not much left in the designation.

THE COURT: Okay. Page and line?

MS. ROSS: We are on, in the binder that you have, the clip report, we're on page 24.

THE COURT: Okay.

MS. ROSS: Starting at the clip that is numbered 119 (reading):

"QUESTION: Okay. And you don't recall -- sorry. Let me phrase that differently.

"You testified that you left UBH in March of 2014?

"ANSWER: That's correct.

"QUESTION: And this discussion was occurring in early 2014?

"ANSWER: That's correct.

"QUESTION: And did that -- was there any resolution to that discussion before you left UBH?

"ANSWER: Not that I can recall at this point.

"QUESTION: So you don't know one way or the other what was happening with this -- what happened with this recommendation?

"ANSWER: That's correct.

"QUESTION: Yeah. And you don't know one way or the other

whether there was other relevant factors that might have affected a decision to adopt or not adopt ASAM?

"ANSWER: That's correct.

"QUESTION: You testified earlier that there is lack of good evidence or consensus about treatment of chronic conditions?

"ANSWER: For behavioral health, yes.

"QUESTION: For behavioral health. And you also testified that medical necessity is a concept that is -- or at least as defined from the Kaiser settlement, that definition of medical necessity is predicated on evidence?

"ANSWER: That's correct.

"QUESTION: My question is: The point you were making here -- again, not on behalf of or a representative of UBH -- was that chronic conditions can -- it can be difficult to assess medical necessity for chronic conditions because the evidence base is not good?

"ANSWER: That's correct.

"QUESTION: But that doesn't mean that -- that insurance companies don't cover chronic conditions?

"ANSWER: That's correct.

"QUESTION: And that didn't mean that UBH did not provide coverage for chronic conditions?

"ANSWER: That's correct.

"QUESTION: This is just a statement about the state of

the evidence?

"ANSWER: That's correct.

"QUESTION: And you also testified, I believe, that you understood UBH's Level of Care and Coverage Determination Guidelines to, in fact, cover chronic care or cover conditions for chronic conditions?

"ANSWER: That's correct. There was no exclusion.

"QUESTION: You testified a little bit about your role in the BPAC?

"ANSWER: Yes.

"QUESTION: That's the Behavioral Analytics and Policy Committee?

"ANSWER: Yes.

"QUESTION: And your role on that committee was to bring outside information from professional organizations, from consumer groups, from practitioners, to help inform the BPAC when it was making decisions about the content of the guidelines?

"ANSWER: That's correct.

"QUESTION: Did you do that regularly?

"ANSWER: Yes.

"QUESTION: Brought in sort of that third-party input?

"ANSWER: Right.

"QUESTION: And the BPAC, the members of the BPAC, considered that input; right?

"ANSWER: Yes.

"QUESTION: Including you?

"ANSWER: Yes.

"QUESTION: Because you were a member of the BPAC?

"ANSWER: Right.

"QUESTION: And that helped inform the BPAC's decision about what should or should not be in a particular Level of Care or Coverage Determination Guideline?

"ANSWER: That's correct.

"QUESTION: Does the BPAC take those recommendations seriously?

"ANSWER: Yes, I think they did take them seriously. There were many incidents where the information helped to inform where people did not have information from before.

"QUESTION: Do you recall any instance where someone on the BPAC thought a recommendation from a third party that you brought to the BPAC would have been the best clinical decision but decided not to implement it because it would have -- it would negatively affect benefit expense?

"ANSWER: I can't recall that coming up, no.

"QUESTION: The BPAC was -- the voting members of the BPAC was clinicians; right?

"ANSWER: Right. They were not doing what I call financial analysis.

"QUESTION: They weren't businesspeople?

"ANSWER: No.

"QUESTION: They were doctors and social workers and doctors and psychologists?

"ANSWER: Right.

"QUESTION: You testified a little bit today about the 'why now' factors?

"ANSWER: Yes.

"QUESTION: And the Level of Care Guidelines?

"ANSWER: Yes.

"QUESTION: Did you understand the 'why now' factors to be an attempt to take a more holistic approach to patient care?

"ANSWER: A holistic approach but also a holistic assessment, yes.

"QUESTION: Because it's about evaluating the entire patient?

"ANSWER: That's correct.

"QUESTION: And not just the symptoms?

"ANSWER: Right.

"QUESTION: You also discussed earlier today that there was a perception in some areas or by some third parties that UBH's guidelines were overly focused on acute care?

"ANSWER: Yes.

"QUESTION: Do you remember that testimony?

"ANSWER: Yes.

"QUESTION: Most of that concern was from the PIC, P-I-C?

"ANSWER: Yes.

"QUESTION: Did you believe that UBH's guidelines were overly focused on acute care?

"ANSWER: No, I didn't believe that. I felt it was a matter of lack of interpretation on the part of PIC, and that's why I spent time working with them and the clinicians that they brought in to work through the differences of understanding of the Level of Care Guidelines.

"QUESTION: And you understood that part of the reason for that -- to be that, again, much of that determination would need to be made on a patient-by-patient basis?

"ANSWER: That's correct.

"QUESTION: Or on a case-by-case basis?

"ANSWER: Right.

"QUESTION: Depending on the patient situation?

"ANSWER: That's correct.

"QUESTION: The 'why now' factors?

"ANSWER: Right.

"QUESTION: And the particular treatment being sought?

"ANSWER: Right.

"QUESTION: In your experience dealing with third-party groups, that was not -- you didn't understand that to be the majority position, did you?

"ANSWER: I'm not sure I understand your question.

"QUESTION: So if -- if PIC approached you to say 'We think your guidelines may be overly focused on providing acute treatment' --

"ANSWER: Uh-huh.

"QUESTION: -- 'or treatment for acute conditions,' you said PIC offered that and maybe one other organization you couldn't remember, but that's not a critique you heard from a large swath of third-party organizations, is it?

"ANSWER: Right. It's not what I heard consistently from all the subspecialty organizations that I worked with. The intent of interacting with them was to get their feedback not only on the parity issues, these kind of issues, but other kinds of issues. So this came from the PIC, which was a very political group but it was a group that was a coalition so it was one of the areas brought up.

"QUESTION: During your time at UBH, were you involved in any discussions about how changes to Level of Care Guidelines would impact benefit expense?

"ANSWER: No.

"QUESTION: More specifically, were you involved in any conversations about how changes to the common criteria wouldn't affect benefit expense?

"ANSWER: No.

"QUESTION: Did you ever discuss with anyone how a proposed change to the common criteria would affect denial rates?

"ANSWER: No.

"QUESTION: Or length of stay?

"ANSWER: No.

"QUESTION: If you turn back to Exhibit 17.

"ANSWER: Okay.

"QUESTION: Again, this is what you understood to be Mr. Shulman's -- the scope of Mr. Shulman's assignment?

"ANSWER: Yes.

"QUESTION: And the services will include but not be limited to creating a Crosswalk or creating a document that Crosswalks Optum's Coverage Determination Guidelines, CDGs, and the LOCG with the new criteria; is that right?

"ANSWER: That's right.

"QUESTION: And then below that there is a subpoint is 'Provide written comments on where the two documents are consistent with each other and where and how they differ'; is that right?

"ANSWER: That's correct.

"QUESTION: Did you understand that to mean comparison of both the CDGs and the LOCGs --

"ANSWER: Yes.

"QUESTION: -- to ASAM?

"**ANSWER:** Yes.

"**QUESTION:** The page ending in Bates Number 731.

"**ANSWER:** Yes.

"**QUESTION:** Again, you understood this to mean -- you understood this to be Dr. Shulman's assessment of the scope of his work?

"**ANSWER:** That's correct.

"**QUESTION:** And he discusses the Optum criteria; is that right?

"**ANSWER:** Yes.

"**QUESTION:** Did you understand that to be both the CDGs and the Level of Care Guidelines?

"**ANSWER:** Right. I believe that to be the case because he reviewed the comment on each of the criteria sets.

"**QUESTION:** And so when he said 'make them consistent with the ASAM criteria,' you understood that to be a reference to both the CDGs and the LOCGs?

"**ANSWER:** Right, because that was part of the huge packet that was sent to him.

"**QUESTION:** Right. And so those in Exhibit, I believe it was, 19?

"**ANSWER:** Yes.

"**QUESTION:** The various attachments that we walked through that were versions of the guidelines?

"**ANSWER:** Yes.

"QUESTION: I understand that those didn't reflect track changes. Plaintiffs' counsel mentioned that; is that right?

"ANSWER: Yes.

"QUESTION: But when you received this document, you understood this to reflect Dr. Shulman's substantive edits; is that correct?

"ANSWER: What my assumption was is that he had read all the documents, and anything in misalignment he would have highlighted in his summary, yes.

"QUESTION: So when -- sorry. I didn't mean to interrupt.

"ANSWER: No. That's all I was going to say.

"QUESTION: So when you read the documents, that's the way you interpreted them?

"ANSWER: Yes.

"QUESTION: You interpreted these documents as indicating Dr. Shulman's opinion about what was consistent with ASAM?

"ANSWER: That's correct.

"QUESTION: So as you read the documents, if Mr. Shulman had left some component of the existing Level of Care Guidelines in the document, you would have understood -- you understood that to mean what?

"ANSWER: As being consistent.

"QUESTION: In Mr. Shulman's opinion?

"ANSWER: Right.

"QUESTION: And on page -- of that exhibit the page ending in 904, it's the second page of the exhibit, Mr. Shulman specifically references '15 files of Optum criteria that I have reviewed and edited'?

"ANSWER: Yes.

"QUESTION: And you understood that to mean that the documents reflected his edits?

"ANSWER: Yes."

THE COURT: Okay.

MS. ROSS: Your Honor, at this time we move to admit Exhibits 407, 409, 879, and 1033.

THE COURT: Other than the objections already been raised, any objections?

MR. ABELSON: No objections.

THE COURT: All right. They're all admitted.

(Trial Exhibits 407, 409, 879, and 1033 received in evidence)

MS. ROSS: Thank you, Your Honor.

MR. RUTHERFORD: Your Honor, the Defense calls Dr. Danesh Alam. We need to distribute some binders.

THE COURT: Okay. I'm going to take a five-minute break.

MR. RUTHERFORD: Okay.

(Recess taken at 9:53 a.m.)

(Proceedings resumed at 10:03 a.m.)

THE CLERK: Please raise your right hand.

DANESH ALAM,

called as a witness for the Defendant, having been duly sworn, testified as follows:

THE CLERK: Thank you.

Go ahead and have a seat. Would you please state your full name for the record, and spell your last name.

THE WITNESS: Danesh Alam. My last name is spelled A-l-a-m, as in Michael.

THE CLERK: Thank you.

And just make sure you speak clearly into the microphone for our court reporter. And there is water there if you need it.

THE WITNESS: Thank you.

THE CLERK: Thank you.

DIRECT EXAMINATION

BY MR. RUTHERFORD:

Q. Dr. Alam, briefly describe your educational background.

A. I'm a psychiatrist. I completed my medical training in India and my psychiatry training at the University of Illinois at Chicago, where I remain on faculty. I completed a fellowship in psychopharmacology and research at the University of Illinois in Chicago.

That's basically my training.

Q. Are you board-certified?

A. I am.

Q. In what areas?

A. I'm board-certified by the American Board of Psychology and Neurology and the American Board of Addiction Medicine.

Q. Are you licensed to practice medicine in any states?

A. I am.

Q. What are those states?

A. I'm licensed to practice in the states of Illinois, New York, Florida, Nevada, and Tennessee.

Q. Broadly speaking, what type of work have you done as a psychiatrist?

A. I've always provided direct patient care. I've done research, and have done some administrative work, as well as advocacy for our patients in the field.

Q. Do you teach psychiatry?

A. I do.

Q. Where?

A. At the University of Illinois at Chicago.

Q. And do you research or write in the area of either mental health or substance use disorders?

A. I do.

Q. Have you received any professional recognition?

A. I have.

Q. What is that?

A. I've been recognized by the American Psychiatric

Association as a distinguished fellow.

Q. Are you familiar with an organization called the American Society of Addiction Medicine or ASAM?

A. I am.

Q. Are you affiliated with ASAM?

A. I'm the president or past president of the local chapter in Illinois for ASAM.

Q. Do you have any involvement with the ASAM national organization?

A. I do.

Q. What is that involvement?

A. I've presented at the national conference. I'm on a couple of national committees.

Q. And do you have any involvement with the Illinois Psychiatric Society?

A. I'm the current president of the Illinois Psychiatric Society.

Q. Now, have you been involved with substance use disorder treatment programs as a healthcare provider?

A. Yes, I have.

Q. In what capacities?

A. I provide direct treatment to two facilities that provide residential care.

Q. Currently?

A. Yes.

Q. What are those facilities?

A. One is a university-based program called Northwestern Medicine Central DuPage. And the other is Sunspire Heartland.

Q. Just very generally speaking, what levels of care do you treat at Sunspire?

A. They provide the Level 4.0, which is detox; 3.7, which is residential; 3.5, another residential level of care; 2.5, partial hospitalization; and 2.1, IOP.

Q. Are those numbers that you're stating right now on the record, are those -- do those come from the ASAM criteria?

A. They do.

Q. And at Sunspire, do you have experience dealing with insurance coverage for the patients treated at Sunspire?

A. Yes.

Q. At DuPage, do you have experience dealing with insurance coverage for the patients at DuPage?

A. I do.

Q. With respect to both of those, do you have experience dealing with various levels of placement guidelines that the insurance companies use for coverage determinations?

A. I do.

Q. Currently, what is your main area of employment?

A. I'm employed by Optum or United Behavioral Health.

Q. What's your position there?

A. My position is behavioral medical director.

Q. What are your responsibilities as behavioral medical director at UBH?

A. I manage the care of our members in a particular area. And I supervise, you know, our care advocacy staff from a clinical perspective. And I also make medical necessity determinations.

Q. And did you say, did you conduct any training in -- with respect to your current position at UBH?

A. I do. I do conduct training.

Q. Does any of that training pertain to the use of the ASAM criteria?

A. It does.

Q. And to which group do you -- with which group of people do you conduct that training?

A. Uhm, I train new hires, the care advocacy staff, you know, my colleagues. So mostly internally.

Q. Within UBH, are you considered a subject matter expert on any particular subject matters?

A. I am.

Q. What are those subject matters?

A. Substance use disorders and transcranial magnetic stimulation.

Q. You understand that you've been identified as an expert witness in this case; is that right?

A. I do.

Q. And on what topics will you be providing an expert opinion?

A. That the UBH Level of Care Guidelines are consistent with the generally accepted standard of care, and the application of the UBH Level of Care Guidelines is consistent with the generally accepted standards of care.

Q. Now, I'm going to direct your attention to an exhibit in the book in front of you, which is 662, which has already been admitted into evidence.

Do you have that in front of you, Dr. Alam?

A. I do.

Q. You indicated a few moments ago that you are familiar with and affiliated with the ASAM organization?

A. Yes.

Q. Are you familiar with the ASAM Criteria?

A. I am.

Q. Do you regularly use the ASAM Criteria in your practice?

A. I do.

Q. Are you familiar with the ASAM Criteria's levels of care?

A. I am.

Q. On a very high level, can you describe how ASAM -- or what are the ASAM levels of care? You used some numbers earlier. Can you give some description to that?

A. Sure. The criteria is the levels of care are organized, you know, with numerical attributes.

So 4.0 is the highest level of care that reflects either inpatient detox or inpatient rehabilitation.

3.0 refers to residential levels of care, which there are four subtypes of residential treatment.

2.0 refers to partial hospital and intensive outpatient levels of care.

And 1.0 refers to outpatient treatment.

And 0.5 refers to early intervention.

Q. Within the Level 3 levels of care, what are the various residential levels that the ASAM Criteria describe?

A. So 3.7 refers to the highest level of care within the residential, you know, subtypes, which is really medically monitored high intensity residential treatment.

3.5 is medically, you know -- actually, it also is high intensity residential treatment.

And 3.3 is for special populations.

And 3.1 is for -- is low intensity residential treatment.

Q. Do the UBH guidelines allow for coverage at each of those residential levels of care?

A. They do.

Q. Does UBH, though, have a separate and distinct guideline for the ASAM 3.5 level of care?

A. They do not.

Q. I'm sorry?

A. They do not. Sorry.

Q. In your experience, though, if a member is requesting a 3.5 level of care, would UBH deny placement merely because there's not a separate and distinct level in the UBH guidelines?

A. No.

Q. Have you had a situation, in your experience, where you personally denied a 3.5 level placement because there was not a specific and distinct 3.5 level of care guideline?

A. Not to my knowledge; I have not issued a denial.

Q. Does UBH contract with facilities in its in-network provider -- with -- with facilities through its in-network provider program?

A. They do.

Q. Do any of those contracts -- do any of those contracts speak to level of care placement at the 3.5 level of care?

A. So in the states where, you know, we are required to use the ASAM Criteria, we do contract with the specific levels.

In the states that we are not required, providers have contracted with us, providers that generally provide 3.5 services have contracted with us and will receive coverage based on that.

MR. RUTHERFORD: I'm sorry, Your Honor?

Oh, I thought you said something.

BY MR. RUTHERFORD:

Q. Is it your opinion the ASAM Criteria are consistent with

generally accepted standards of care?

A. Yes.

Q. Do you believe that the UBH guidelines are consistent with generally accepted standards of care?

A. Yes.

Q. Is it your opinion that the UBH level of guidelines for substance use disorders, specifically, are consistent with generally accepted standards of care?

A. Yes.

Q. Are you familiar with the concept of "why now" that's been used between 2011 and 2016 in the UBH guidelines?

A. I am.

Q. Do you recall, sort of generally, which years the "why now" concept appeared in the UBH guidelines?

A. I believe it was between 2014 and 2016.

Q. Do you have an understanding as to the meaning of the "why now" concept as used in the UBH guidelines?

A. I do.

Q. What's that?

A. So "why now" is really a broad term that is -- that has a couple of components. One is really what the patient's perspective needs are. And the second part of that is what the clinician's assessment of the patient's needs are.

Now, these two components are, you know, really looked under what we call a biopsychosocial perspective. In fact, I

think the criteria also talks about the individual level of function, the environmental factors. So it really is a broad term that describes a number of issues that are bringing the member into treatment.

Q. And, in your view, is this "why now" concept utilized in the same way at each of the different levels of care within the UBH Level of Care Guidelines?

A. That's correct. The way the criteria is applied is at each level you really take a new look and add the new information that -- that -- the information that may have changed since the last level of care. Absolutely.

Q. What do you mean by that, that you take a new look at --

A. So if a patient is going from, let's say, an inpatient level of care to an intensive outpatient level of care, you're not still looking at the data that was obtained at the inpatient level. You're looking at the new data that's available for the new level of care. And you're looking at it, really, from trying to match, you know, the patient's symptoms to the level of care.

Q. In your opinion, is -- is the "why now" concept limited to acute factors?

A. No, it is not.

Q. Does it include -- potentially include acute factors?

A. It does.

Q. So, now, directing your attention to Exhibit 1, which is

in the front of the book you have in front of you.

MR. RUTHERFORD: It's been previously admitted, Your Honor.

BY MR. RUTHERFORD:

Q. And specifically to Exhibit 1, page 0002. Do you recognize this document?

A. I do.

Q. What is it?

A. It's the 2011 Level of Care Guidelines at UBH.

Q. Are you generally familiar with the structure of the 2011 Level of Care Guidelines?

A. I am.

Q. Within the 2011 Level of Care Guidelines, are there specific -- are there criteria, I'm sorry, specific to substance use disorders and the levels of care for substance use disorders?

A. Yes.

Q. And is there a specific section for residential treatment for substance use disorders?

A. There is.

Q. Directing your attention to Exhibit 1, page 0056.

Please tell the Court, what are the criteria set forth beginning on Trial Exhibit 1-0056.

A. It's the 2011 Level of Care Guidelines, residential rehabilitation for substance use disorders.

Q. Okay. And then beginning on page 1-0056 and then continuing on to page 1-0059, do you see there are two sections?

A. Yes.

Q. What is Section 1?

A. Section 1 is a list of criteria that is required to be met.

Q. And then Section 2?

A. And has additional criteria which require that all of the elements should be met.

Q. Okay. So what's the difference between Section 1 and Section 2, in other words?

A. So you have to pick one from Section 1 and all from Section 2.

Q. How -- so you need to establish at least one of the six criteria in Section 1, but all of the seven criteria in Section 2; is that right?

A. That's right.

Q. Now, are -- in your opinion, are each of the six criteria here, which -- are these the potential bases for admission, just to be clear?

A. Yes.

Q. Are any of these six criteria inconsistent, in your opinion, with generally accepted standards of care for admitting a patient to residential rehabilitation for substance

use disorders?

A. No.

Q. And is your opinion that -- are there any -- is it your opinion that there are any one of these six criteria that provide too high a bar for admission to residential treatment for substance use disorders?

A. They do not.

Q. Why is that?

A. Well, you know, as a clinician and someone who does reviews, I look at this criteria and I say that they really are very broad. They actually capture all possible instances.

When you're looking at 24-hour confinement in a 24-hour setting, the evaluation that is needed to actually enter that is a risk -- is what's called the risk assessment. So what are the risks that need to be addressed by confining a member or a patient in a 24-hour setting.

And if you look at the criteria itself, they are broad. If you look at, for example, criteria number six, you know, a patient just saying -- see, it talks about subjective severity. So all a patient has to say is that I have a severe problem with substances and some social issues related to that, and that's enough.

So the criteria really allows a lot of scenarios to -- to lead to an admission. It really allows clinical judgment to drive the decision making.

Q. Let's take another example.

So how, in your opinion, is criteria number three consistent with generally accepted standards of care for admission to a residential treatment facility for substance use disorders?

A. So that particular point is criteria for a number of other, you know, guidelines. And that's really referring to having a medical problem that will worsen with continued use. So it is consistent with the generally accepted standards that you need a higher level of care to address that risk.

Q. A medical problem being separate from the behavioral health problem?

A. That's correct.

Q. So the second section you indicated, and all of the following, each of these seven criteria would need to be met for admission to a residential treatment center for substance use disorders; is that right?

A. That's correct.

Q. Okay. Now, directing your attention to -- first, to 2a., which states:

"Within 48 hours of admission, the following occurs:

A., a psychiatrist/addictionologist completes a comprehensive evaluation of the member."

Do you see that?

A. I do.

Q. Is that requirement for admission to a residential treatment facility consistent with generally accepted standards of care?

A. It is.

Q. Why is that?

A. It is prudent to have a physician see a patient in a setting which requires 24-hour confinement.

It really is the community standard. It is the expectation that a patient will be seen by a physician as promptly as possible.

Q. You mentioned earlier the ASAM Level 3.5. Do you recall that?

A. I do.

Q. In your opinion, would this requirement of a 48-hour comprehensive evaluation preclude UBH coverage for a level of care to 3.5 facility?

A. It does not.

Q. Why is that?

A. Uhm, because even the 3.5 criteria does mention the need for the availability for medical services.

And, you know, it's about being practical. You know, we know a patient needs to be seen. And so I think it actually matches the 3.5 criteria.

Q. Directing your attention, now, to a Criteria 5, which is on page 1-0057. Do you have that in front of you?

A. I do.

Q. It reads:

"The treating psychiatrist/addictionologist and, whenever possible, the member collaborate to update the treatment plan at least every five days in response to changes in the member's condition, or provide compelling evidence that continued treatment in the current level of care is required to prevent acute deterioration or exacerbation of the member's current condition."

Do you see that?

A. I do.

Q. And is that requirement, in your opinion -- well, first of all, let's look at the every five days.

Are the requirement for a treatment plan at least every five days consistent with generally accepted standards of care?

A. It is.

Q. Why is that? For residential treatment for substance use disorder.

A. I think it's reasonable to take a look at your treatment plan every week, to address, you know, progress, et cetera. And that's how it's generally done in clinical practice.

Q. And, in your opinion, would the requirement of a treatment plan update every five days preclude placement at an ASAM 3.5 level of care?

A. It does not.

Q. Now, looking at the paragraph as a whole, do you think the paragraph as a whole is consistent with generally accepted standards of care?
A. Except for the word "compelling."
Q. Okay. Why is that not consistent?
A. I just don't think it's a medical term.
Q. So aside from "compelling," which comes after "or provide," is the rest of the paragraph there consistent with generally accepted standards of care?
A. Yes.
Q. And do you know whether this word "compelling" appears again in later years?
A. It does.
Q. Okay. Now, directing your attention to Exhibit 2, at page 00002. Do you recognize that document?
A. I do.
Q. What is it?
A. It's the 2012 Level of Care Guidelines at UBH.
Q. Does the 2012 Level of Care Guidelines also have criteria specific to substance use disorders for the various levels of care?
A. Yes.
Q. And does it specifically have a placement guideline for residential rehabilitation placement for substance use disorders?

A. It does.

Q. Okay. Directing your attention to Exhibit 2 -- at page --

MR. RUTHERFORD: I'm sorry, Your Honor.

BY MR. RUTHERFORD:

Q. Directing your attention to Exhibit 2-0062.

What criteria, Dr. Alam, are set forth beginning on page 2-0062 and continuing to 2-0065?

A. It's the 2012 Level of Care Guidelines, residential rehabilitation substance use disorders.

Q. And is the structure of this guideline the same basic structure as the 2011 guideline?

A. It is.

Q. With the section where six -- one of the six criteria need to be met?

A. Yes.

Q. And then a section where all of the seven criteria need to be met?

A. Yes.

Q. For placement in a residential treatment facility for substance use disorders?

A. Yes.

Q. Okay. Again, looking at the six criteria in the first section, any one of which need to be met, in your opinion, do any of these criteria -- are any of these criteria inconsistent with generally accepted standards of care for placement in a

residential treatment facility for substance use disorders?

A. They are not.

Q. And looking down to Section 2 here, "And all of the following," and directing your attention, first, to paragraph 2a., do you see that?

A. I do.

Q. Is that the same requirement for a 48-hour comprehensive evaluation that we just discussed in the 2011 Level of Care Guidelines?

A. It is.

Q. And do you believe that this requirement is consistent with generally accepted standards of care?

A. It is.

Q. For the same reasons that you -- that you stated with respect to the same language in the 2011 Level of Care Guidelines?

A. Yes.

Q. And then to --

THE COURT: So stop there.

Turn to Exhibit 662 and show me where in the 3.5 level of care criteria it requires a doctor's -- an M.D., within 48 hours, to do the things that are required by that level of care guideline.

THE WITNESS: I think we -- from the broad difference between the UBH --

THE COURT: So, in other words, it does not.

THE WITNESS: It does not specifically say "48 hours," but it does talk about the need for medical monitoring and availability.

THE COURT: Well, it doesn't say "complete a comprehensive evaluation"; right?

THE WITNESS: Right. It doesn't specifically say that.

THE COURT: It talks about the availability of a doctor, or a consultation with a doctor; right?

THE WITNESS: It talks about really matching the patient's symptoms with --

THE COURT: Look at page 662-274, if you would.

And under support systems it says, all programs, 3.5 programs, necessary support systems include, and then it has a list -- which was the only place where I could find; maybe you can find other places -- where it referred to a physician. Nothing in that requires a physician to do anything like what -- to do what is required by the Level of Care Guidelines; right?

THE WITNESS: That is correct.

THE COURT: Thank you.

So this is an instruction to you. I'm not going to take this high level, oh, it's all sort of very generally accepted standards of care.

You're going to have to dig down and point it out to me because by now you've had chapter and verse on why the details are inconsistent. So you're going to have to go and dig down.

Okay. Go ahead.

BY MR. RUTHERFORD:

Q. Dr. Alam, directing your attention to the criteria in number 3. Do you see that, at Exhibit 2-0063?

Criteria 3 states:

"Subsequent psychiatric evaluations and consultations are available 24 hours a day. Visits with the treating psychiatrist and addictionologist occur at least two times per week."

Do you see that?

A. I do.

Q. And, in your opinion, is that requirement for residential placement for substance use disorders consistent with generally accepted standards of care?

A. In my opinion, yes.

Q. Okay. Can you explain why.

A. The expectation that a patient in a 24-hour confinement is seen by a physician a couple of times a week is reasonable and generally followed in the community.

Q. And why is that -- is there any reason to require that with respect to residential treatment placement as opposed to another level?

A. As opposed to an outpatient or --

Q. Correct.

A. It's -- usually there is a degree of risk that has led patients into this level of care. Part of our role is to monitor that safe and appropriate care as provided to our members. And part of that monitoring role, you know, requires that we make sure that a physician is seeing our members. And a number of times this is the first level that members enter; and we don't know much about them. And so it is prudent to expect phys- -- close physician follow up.

Q. Now I want to direct your attention, then, to number 4, just right below it. That criteria states:

> "All relevant general medical services, including assessment and diagnostic treatment and consultative services, are available as needed and provided with an urgency that is commensurate with the member's medical need. Co-occurring medical conditions can be safely treated in this level of care."

Do you see that?

A. I do.

Q. What is a medical service or a medical need? What is this speaking to?

A. This is really speaking to co-morbid conditions that a patient may have, and the need for treating these co-morbid conditions.

Q. What's an example of a medical co-morbid condition?

A. An example would be for an IV drug user, you know, an infection, injection site infection.

Q. Is this provision, in your opinion, consistent with generally accepted standards of care?

A. It is.

Q. Why?

A. The expectation that someone in a 24-hour confinement is seen by a physician, their medical conditions are actively treated; that's consistent.

Q. And would this requirement of safely treating co-occurring medical conditions preclude, in your opinion, placement at a level of care lower than an ASAM 3.7 for residential treatment?

A. It does not.

Q. And why not?

A. We have contracted with a number of facilities that just provide 3.5 services. And we -- a number in network facilities do provide the service and are compliant with this expectation. So when we get a request, I mean, we do apply the general residential criteria even for the 3.5 level of care.

Q. What are you looking for, though, when you want to ensure that a level of care can safely treat a medical condition? What are the qualities of a facility that you're looking for?

A. That -- that -- first of all, that they have, you know, involvement of a physician in a timely manner; that they have,

you know, the facilities to manage a medical condition; and that they -- they -- the expectation of 24-hour monitoring that takes place.

Q. Not necessarily that a physician is on site the whole time?

A. That's correct.

Q. Okay. Now, directing your attention to paragraph 5 below that, do you have that in front of you?

A. I do.

Q. Is paragraph 5 the same language as I had you discuss in the 2011 Level of Care Guidelines?

A. Yes.

Q. And is your opinion, regarding the entirety of that paragraph, the same with respect to the 2012 Level of Care Guidelines?

A. It is.

Q. Which is that the -- am I right that the paragraph is consistent with generally accepted standards of care except with respect to the use of the word "compelling"?

A. Yes.

Q. Now, directing your attention to paragraph 5a., underneath paragraph 5. This is the paragraph beginning "Treatment in a residential setting is not for the purpose of providing custodial care."

Do you see that?

A. I do.
Q. Was that paragraph in the 2011 Level of Care Guidelines?
A. I don't recall, actually.
Q. This is the first time --
A. Yes, it is.
Q. -- that this provision has appeared; correct?
A. Yes.
Q. And this -- this paragraph, what does this paragraph pertain to? The concept of what?
A. The concept of custodial care.
Q. And is custodial care -- let me ask it this way: Do you know whether custodial care is generally defined in the UBH health plans?
A. It is.
Q. And do you have an opinion as to whether or not this custodial care definition in 5a. is consistent with generally accepted standards of care?
A. It is.
Q. And is it?
A. It is.
Q. In your opinion, is it consistent with generally accepted standards of care to exclude coverage that is solely to prevent runaway, truancy, and legal problems?
A. It is.
Q. Why is that?

A. Custodial care is sort of a universal concept. CMS has defined it. It's -- and it's part of, you know, the need for medical necessity, really.

Q. Now directing your attention at the top of the next page, at 2-0064, at 5b. Do you see that?

A. I do.

Q. States:

"Treatment in a residential setting is for the active treatment of a substance use disorder."

Do you see that?

A. I do.

Q. And the rest of the paragraph, including the subparts, discuss active treatment?

A. Yes.

Q. Have you reviewed this entire 5b.? 5b. -- paragraph 5b. and then the five subparts?

A. Yes.

Q. And do you consider 5b. to be consistent with generally accepted standards of care?

A. I do.

Q. Why is that?

A. Again, active treatment is really the expectation of medical necessity; that if you're confined in a 24-hour setting, hopefully, you're there to receive treatment. And when the treatment ends, you're able to transition to a less

restrictive setting.
Q. Okay. Directing your attention to Exhibit 3, page 0002. Do you recognize that document?
A. I do.
Q. What is it?
A. It's the 2013 Level of Care Guidelines, UBH.
Q. Okay. And then do the 2013 Level of Care Guidelines also have specific level of care criteria for residential placement for substance use disorders?
A. They do.
Q. Okay. Directing your attention to Exhibit 3-0067. And what are the criteria set forth beginning on page 3-0067?
A. It's the 2013 Level of Care Guidelines for substance use disorders residential rehabilitation.
Q. And is the general structure of the 2013 level of care guideline for residential placement for substance use disorders consistent with the structure in the prior two years?
A. Yes.
Q. All right. Directing your attention, first, to the six factors under "Any one of the following criteria must be met."
Do you see those?
A. I do.
Q. And are these six criteria, in your opinion, consistent with generally accepted standards of care?
A. Yes.

Q. Are any of them inconsistent with generally accepted standards of care for the purposes of placement in a residential treatment facility for substance use disorders?

A. Not in my opinion.

Q. And are your reasons the same reasons stated with respect to these same set of factors for 2011 and 2012?

A. Yes.

Q. And down below it has the same section criteria that all must be met in order to get placement to a residential treatment center --

A. Yes.

Q. -- for substance use disorders?

A. Yes.

Q. Although, is there an additional factor? Seven for the years before. And this year, how many criteria must be met?

A. Eight.

Q. Directing your attention to paragraph 2a., 3, 5, and 6 with its subparts. Do you see those?

A. I do.

Q. Are these four paragraphs substantively the same language we saw in the 2012 residential rehabilitation guidelines for substance use disorder?

A. Yes.

Q. And is your opinion, as to whether or not they are consistent with generally accepted standards of care, the same

with respect to these in 2013?

A. Yes.

Q. And what is that opinion?

A. That they are consistent with the generally accepted standards of care.

Q. Now, directing your attention to the top of page 3-0069, where it says "c." Do you see that?

A. I do.

Q. Part 5c. So, again, paragraph 5 is describing what concept, Dr. Alam?

A. It's the concept of custodial care.

Q. And can you read the last sentence in that -- in paragraph 5?

A. C?

Q. Yeah. Paragraph 5, it indicates: "Custodial care is characterized by the following."

Do you see that?

A. I do.

Q. And to C, can you please read C.

A. (Reading)

"The intensity of active treatment provided in a residential setting is no longer required or services can be safely provided in a less intensive setting."

Q. Is that definition of custodial care -- well, is that a definition of custodial care?

A. One of the components of custodial care.

Q. And is that definition consistent with generally accepted standards of care?

A. It is.

Q. And, as you mentioned earlier, is the custodial -- for 2013, was custodial care defined within UBH's health plans?

A. Yes.

Q. Directing your attention, now, to Trial Exhibit 5. We're going to skip Exhibit 4 for the moment. Page 0001.

Do you recognize this document?

A. I do.

Q. What is it?

A. It's the UBH 2015 Level of Care Guidelines.

Q. And in 2015, did the UBH Level of Care Guidelines have specific criteria for residential placement for substance use disorders?

A. Yes.

Q. Directing your attention to Trial Exhibit 5-0081.

What criteria are set forth on Trial Exhibit 5-0081, if you know?

A. It's the 2015 Level of Care Guidelines' residential rehabilitation criteria.

Q. Directing your attention, first, to the shaded box at the top. The second paragraph which reads:

"The course of treatment in residential

rehabilitation is focused on addressing the 'why now' factors that precipitated admission (e.g, changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that rehabilitation can be safely, efficiently, and effectively continued in a less intensive level of care." Do you see that?

A. I do.

Q. And with respect to placement in the residential rehabilitation facility for substance-related disorders, is this provision consistent with generally accepted standards of care?

A. It is.

Q. Can you explain why?

A. The "why now" here describes two components: One, the patient's goals or the reason the patient is coming, you know, to receive this 24-hour confinement-related treatment. And the other part is obviously the clinician's assessment of the member or patient.

And this information is looked at from a biopsychosocial perspective with, really, an emphasize on psychosocial and environmental factors, the level of functioning, et cetera. And this is applied. And this becomes, really, your treatment plan.

Q. Does this have any special significance, given that it's

placement for residential rehabilitation for substance use disorders?

A. Yes. Obviously, it's for individuals who are at a certain degree of risk. And the risk assessment is required in a more intensive treatment.

Q. Do you have any concerns that this provision overemphasizes the "why now" factors?

A. I do not.

Q. Do you have any concerns that this provision overemphasizes acute changes in signs and symptoms?

A. I do not.

Q. Do you have any concerns that this provision underemphasizes chronic factors?

A. It does not.

When you talk about acute symptoms, you're really referring to the acute changes of a chronic condition.

Most of what we treat are chronic conditions. So when you're talking about acute changes, you're referring to the acute changes that are contributed because of the underlying chronic condition.

Q. When you say "most of what we treat are chronic conditions," are you talking about substance use disorders? Mental health? What are you talking about?

A. You could pick. Most of what we treat now, whether it's substance use disorders or mental health conditions, they are

chronic conditions.

Q. Now, directing your attention a little farther down the page, to 1.3.

Do you see that?

A. I do.

Q. Where it reads the "why now" -- well, the admission criteria are structured differently in this guideline; is that right?

A. Yes.

Q. Are each of these criteria required for there to be admission to a residential rehabilitation facility for substance use disorders?

A. Yes.

Q. So then directing your attention to 1.3, one of those required criteria reads:

> "The 'why now' factors leading to admission and/or the member's history of response to treatment suggests that there is imminent or current risk of relapse which cannot be safely, efficiently, or effectively managed in a less intensive level of care."

Do you see that?

A. I do.

Q. And is that requirement consistent with generally accepted standards of care?

A. It is.

Q. Why? I'm sorry, for residential placement for substance use disorders?

A. Yes.

Q. Why?

A. If you see, that point really has two components. You can get into residential if the "why now" factors alone, you know, require 24-hour care. And the second point is referring to a risk of relapse and needs for a structure to prevent that. That's consistent with the generally accepted standards of care.

THE COURT: Can I ask you a question? Isn't that second part, by your definition, included in the "why now" factors?

THE WITNESS: It is.

THE COURT: Thank you.

THE WITNESS: And, Your Honor, if I may.

THE COURT: Sure.

THE WITNESS: Some of these points are redundant because our frontline, we have a multidisciplinary team; so we have a number of clinicians. Some of these points we have to reiterate because, you know, a number of our patients may only receive residential treatment. So this may be the entry into, sort of, the mental health/substance abuse system. So there is some redundancy that is expected.

In medical care, repetition -- we're still learning from

the FAA and the error rates, so repetition is sort of the norm.

THE COURT: Well, I appreciate that way of looking at this.

The other way of looking at this is that people reading this, who didn't draft them, are trying to figure out what they mean and trying to figure out what the "why now" factors mean, see what it means and see what it doesn't mean, and distinguish it from other factors.

So aren't you at risk that when somebody reads this sentence they will think that "why now" is not as broad as you -- as you understand it to be?

THE WITNESS: Point taken, yes.

THE COURT: Thank you.

BY MR. RUTHERFORD:

Q. Directing your attention to this phrase "imminent or current risk of relapse."

Do you see that?

A. I did.

Q. 1.3. And down in 1.3.2, it talks about "immediate or imminent danger of relapse."

Do you see that?

A. I do.

Q. Do those basically mean the same thing?

A. They do.

Q. What do they mean? What does it mean to be in imminent

danger of relapse?

A. It means that without the structure of a 24-hour setting, the member or patient is going to resume use of substances, putting himself or herself in danger, basically.

Q. In your opinion, would this language preclude coverage at a -- for instance, at an ASAM Level 3.5?

A. It would not.

Q. Why not?

A. Because, again, the risk assessment that is used in ASAM, to arrive at a level of care determination, requires certain elements to be met to meet residential criteria.

Q. Down -- directing your attention down to 1.4, a little bit lower. This is also a requirement for admission to residential rehabilitation for substance-related disorders. Is that right?

A. Yes.

Q. Okay. It reads:

> "The 'why now' factors leading to admission cannot be safely, efficiently, or effectively assessed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors"; and then says "examples include." Do you see that?

A. I do.

Q. Is this provision consistent with generally accepted standards of care for residential treatment for substance use

disorders?
A. It is.
Q. Why?
A. You know, the first point we talked about, really, the risk, which is imminent danger of relapse or imminent risk of relapse.

And the second point is really reemphasizing, is this the appropriate level of care given the "why now" factors.

So it's another sort of check, again, for our team to say, well, okay, we've now assessed the risk; is this the right level of care? And all of the, you know, perspective of safely, efficiently, and effectively assessing and treating the member at this level of care.

Q. So you see where it says "acute changes in the member's signs and symptoms"?
A. I do.
Q. In 1.4?
A. Yes.
Q. Okay. Does this language -- does this language concern you with respect to an overemphasis on acute and an underemphasis on chronicity?
A. It does not.
Q. Why not?
A. It's talking about the acute changes, probably, of a chronic condition. Even chronic conditions have, you know,

episodic, acute exacerbations. So this is referring to that.

Q. Now, directing your attention to Exhibit 5-0082, to 2.2, the top of Exhibit 5-0082.

Do you see that?

A. I do.

Q. Where it states:

"Treatment is not primarily for the purpose of providing custodial care."

Do you see that?

A. I do.

Q. And then directing your attention down to 2.2.3, it reads:

"Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively."

Do you see that?

A. I do.

Q. And is that part of the definition of custodial care?

A. It is.

Q. And is this definition of custodial care consistent with generally accepted standards of care, in your opinion?

A. It is.

Q. Why?

A. When you don't need the care of -- of a medically trained individual, do you need -- do you continue to need the current intensity of treatment?

Q. At the residential --

A. Correct, at the 24-hour confinement.

THE COURT: What is "medically trained"?

THE WITNESS: Anyone that requires licensure to take --

THE COURT: It's not limited to physicians?

THE WITNESS: It's not.

BY MR. RUTHERFORD:

Q. Directing your attention to Exhibit 6 and Exhibit 7, at pages 0001 in each of those exhibits. Do you have those in front of you?

A. I do.

Q. What are Exhibits -- do you recognize Exhibit 6 and 7?

A. I do.

Q. What are they?

A. They are the two versions of the 2016 Level of Care Guidelines, UBH Level of Care Guidelines.

Q. And do both of these 2016 Level of Care Guidelines have criteria specific to residential treatment placement for substance use disorders?

A. They do.

Q. And is the language the same for each of these versions in 2016?

A. In general, yes.

Q. Now, just with respect to that criteria for residential

treatment placement for substance use disorders?

A. Yes.

Q. It's the same language?

A. Yes.

Q. So directing your attention to Exhibit 6-0090. What criteria set forth on Exhibit 6-0090.

A. I see it's the 2016 Level of Care Guidelines, residential rehabilitation.

Q. And then directing your attention to Exhibit 7-0091. 7-0091.

A. Yes.

Q. Do you have 7-0091 in front of you?

A. I do.

Q. What is that?

A. It's the 2016 Level of Care Guidelines, residential rehabilitation.

Q. And so the language is the same in both?

A. It is.

Q. And is your -- will your opinion be the same with respect to both?

A. Yes.

Q. Directing your attention to Trial Exhibit 6-0090, to the shaded box at the top. Second paragraph. Do you see that?

A. I do.

Q. The paragraph beginning with "The course of treatment in

residential rehabilitation."

A. Yes.

Q. Okay. Is that the same provision that you just discussed from the 2015 Level of Care Guidelines for substance use -- for residential treatment and substance use disorders?

A. It is.

Q. And is your opinion, with respect to whether this provision is consistent with generally accepted standards of care, the same with respect to 2016, both versions, as it was with respect to 2015?

A. It is.

Q. And what is that opinion?

A. That the description here is consistent with the generally accepted standards of care.

Q. And then directing your attention down to the provisions that say "1.3" and "1.4." Do you see that?

A. I do.

Q. And the language at 1.3, 2 regarding imminent -- I'm sorry, immediate or imminent danger of relapse. Do you see that?

A. I do.

Q. Is that the same language as you discussed for the 2015 Level of Care Guidelines?

A. It is.

Q. And is it your opinion that these provisions are

consistent with generally accepted standards of care for residential rehabilitation for substance use disorders?

A. Yes.

Q. For the same reasons as you testified earlier?

A. Yes.

Q. Okay. Now, directing your attention to exhibit --

MR. RUTHERFORD: One moment, Your Honor. I'm sorry.

BY MR. RUTHERFORD:

Q. Directing your attention to Exhibit 6. I'm sorry, to Exhibit 4, to the 2014 Level of Care Guidelines.

Do you have that in front of you?

A. I do.

Q. Are you familiar with the 2014 Level of Care Guidelines?

A. I am.

Q. And aside from the formatting, is the -- do the 2012 -- I'm sorry, the 2014 Level of Care Guidelines, at Trial Exhibit 4, also contain criteria specific to residential treatment for substance use disorders?

A. Yes.

Q. Directing your attention to page 4-0077, starting with the shaded box at the top, second paragraph that begins with "The course of treatment," do you see that?

A. I do.

Q. Is that the same language that appeared in the 2015 and 2016 --

A. It is.

Q. -- Level of Care Guidelines?

And is your opinion, with respect to whether or not this provision is consistent with generally accepted standards of care, the same as it was for those other years?

A. It is.

Q. Now, directing your attention -- staying on 4-0077, do you see the column that says "Admission"?

A. I do.

Q. What is contained in the column that says "Admission"? What information is that?

A. It's the criteria required for admission.

Q. And where it says "and," it means that each one of these criterion must be met; correct?

A. Yes.

Q. Directing your attention to the third bullet point, the third bullet point states:

> "The 'why now' factors leading to admission suggest that physical complications, if present, can be safely managed."

Do you see that?

A. I do.

Q. What do you understand "physical complications" to mean?

A. To mean medical conditions.

Q. And is this requirement that physical complications, which

you understand to be medical conditions, can be safely managed a requirement that is consistent with generally accepted standards of care?

A. It is.

Q. Why is that?

A. The expectation that you're in a 24-hour care setting and that if you have medical conditions that they would be addressed, you know, safely.

Q. And does it concern you that this requirement regarding physical complications does not also require that these physical complications can be effectively treated?

A. It does not.

I would be concerned if it did, because we're talking about behavioral health or substance abuse settings; in this particular case, a 24-hour residential setting.

You know, as a practitioner, all of our psychotropic medications now have a warning around cardiac side effects. So if one of my patients actually needs medical care, they probably need to go to a medical setting. So to -- to promise or expect that one of our members will receive effective medical care in a substance use setting, that may be a stretch. So as long as they can provide safe care for what's needed, I'm satisfied.

THE COURT: So this purposefully excludes the notion of effective care for physical complications if present?

THE WITNESS: That's correct.

BY MR. RUTHERFORD:

Q. Directing your attention to page 4-0078, which is just the next page. The first bullet point under "Admission," do you see that?

A. I do.

Q. Okay. It reads:

> "The 'why now' factors leading to admission and/or the member's history of response to treatment suggests that there is imminent or current risk of relapse which cannot be safely, efficiently, or effectively managed in a less intensive level of care."
>
> And then it gives some examples. Do you see that?

A. I do.

Q. And is this -- while there aren't numbers next to it, is this essentially the same language that you discuss with respect to the 2015 and 2016 Level of Care Guidelines?

A. It is.

Q. And is your opinion, with respect to whether or not this language is consistent with generally accepted standards of care, the same with respect to 2014 as it was with respect to 2015 and '16?

A. It is.

Q. Okay. Now, directing your attention down to Trial Exhibit 4-0079. Under "or" do you see that?

A. I do.

Q. It says:

"The 'why now' factors leading to admission cannot be safely, efficiently, or effectively addressed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors."

And then it gives some examples that go to the next page.

Do you see that?

A. I do.

Q. And is that the same language as you testified about from Section 1.4 in the 2015 and 2016 Level of Care Guidelines?

A. It is.

Q. And is your opinion, with respect to whether or not this language is consistent with generally accepted standards of care, the same as it was for 2015 and '16?

A. It is.

Q. And what is that opinion?

A. That the language is consistent with the generally accepted standards of care.

Q. Now, directing your attention back to Trial Exhibit 4-0077, to the middle column, under "Level of Care Criteria." Do you see that?

A. I do.

Q. What information is this in this middle column, of "Level

of Care Criteria"?

A. It's the evaluation and treatment planning column.

Q. In the -- don't have numbering here, but do you see the last full paragraph, starting with "Custodial care"? On 4-0077, under continued service --

A. Yes, I do.

Q. Reads:

"Custodial care involved services that don't seek to cure are provided when the member's condition is unchanging, are not required to maintain stabilization, or don't have to be delivered by trained clinical personnel." Do you see that?

A. I do.

Q. And do you know whether or not in 2014 UBH's health plans defined "custodial care"?

A. They do.

Q. Also, on 4-0077, under "Evaluation and treatment planning," do you see that language?

A. I do.

Q. What does "Evaluation and treatment planning" cover?

A. It covers, you know, the issues related to the patient's specific treatment plan.

Q. Second of those two bullet points requires that the evaluation and treatment planning -- as part of evaluation and treatment planning, that the psychiatrist or addictionologist,

in conjunction with the treatment team, completes the initial evaluation within 24 hours of admission.

Do you see that?

A. I do.

Q. And is that requirement of an initial evaluation within 24 hours of admission to residential rehabilitation for substance-related disorders consistent with generally accepted standards of care?

A. It is.

Q. Why?

A. It's -- to have a patient seen as soon as possible in a 24-hour confinement setting is -- is generally, you know, expected. You want that to happen.

Q. In your opinion, is this -- does this provision preclude members who are seeking placement at an ASAM Level 3.5 facility?

A. It does not.

Q. Why not?

A. Because this is something we emphasize. But we'll work with the facilities. So it's not something that alone I would use to issue a denial; that your doctor can't see you within 24 hours.

And, for example, in our state, where ASAM Criteria is required by law, patients are required to be seen within 24 hours.

Q. Now, directing your attention back to Exhibit 2, at 0029. Let me know when you have that in front of you.

A. I do.

Q. Okay. Paragraph 5. You see this is a -- well, tell me, what criteria begin on Trial Exhibit 2-0028?

A. It's the residential treatment mental health conditions 2012 Level of Care Guidelines.

Q. Okay. This is different criteria from the substance use disorder criteria?

A. It is.

Q. Directing your attention to paragraph 5. Paragraph 5 states:

> "The provider and, whenever possible, the member collaborate to update the treatment plan at least weekly in response to changes in the member's condition, or provide compelling evidence that continued treatment in the current level of care is required to prevent acute deterioration or exacerbation of the member's current condition."

Do you see that?

A. I do.

Q. And is this paragraph, in your opinion, consistent with generally accepted standards of care for residential placement for mental health conditions?

A. Again, except for the word "compelling," yes.

Q. But, otherwise, in your opinion, it is?

A. It is.

Q. Why is that for mental health conditions?

A. That, you know, the expectation that you take a look at how the patient is doing and update the treatment plan at least on a weekly basis, I believe that's the standard of care. And providing evidence for the continued need for 24-hour confinement, that's within the expected standards of care.

Q. And at 5a., if I could direct your attention to 5a. and its subparts.

What do 5a. and its subparts, in short, describe?

A. They describe the custodial care description.

Q. And do you have an understanding as to whether in 2012 UBH's health plans defined custodial care?

A. Yes.

Q. And down to paragraph 5b., which also has five subparts. Do you see that?

A. I do.

Q. What does paragraph 5b. describe?

A. It describes -- it's a definition of active treatment, and then has more specifics around what is defined as active treatment.

Q. Is this definition of active treatment similar in all material respects as to the definitions of active treatment that you previously discussed today?

A. Yes.

Q. Is it your opinion that 5b. and its definition of active treatment is consistent with generally accepted standards of care?

A. It is.

Q. For the reasons that you stated earlier?

A. Yes.

Q. Now, directing your attention to page 2-0047.

What level of care criteria are set forth on page 2-0047, Dr. Alam?

A. It's the 2012 intensive outpatient program substance use disorders.

Q. And is the structure -- how does the structure of the 2012 intensive outpatient program substance use disorder criteria compare to the residential treatment substance use disorder criteria that you were discussing earlier?

A. It's similar.

Q. In what -- in what general respects?

A. In general layout, you know, there's a shaded box with some descriptives. And then you have a checklist that one of the criteria has to be met, and then all of the following.

Q. So I want to direct your attention to one of the required criteria under any -- I mean under "and all of the following." So go to, if you could, Trial Exhibit 2-0048, at Criteria 6. And this reads, Criteria 6:

"Within the first three days of treatment" -- this being intensive outpatient treatment -- "the following should occur:

"A psychologist our addictionologist completes a comprehensive evaluation of the member when the member has been directly admitted from an inpatient setting."

Do you see that?

A. I do.

Q. Is that requirement, in your opinion, from inpatient to intensive outpatient, a requirement that is consistent with generally accepted standards of care?

A. It is.

Q. Why is that?

A. Most of our patients get into IOP. They've not had care before. But, more importantly, IOP is a common step down from an acute treatment setting such as inpatient.

So they transition from a higher level of care to IOP. That can -- there's a significant transition, especially for an individual who has recently been at higher risk, as determined by a risk assessment. So it is prudent to make sure that a patient is seen quickly after an acute transition between levels of care.

Q. And, in your opinion, does this requirements create a barrier of access to placement in an intensive outpatient setting?

A. It does not.

Q. Directing your attention to Exhibit 5, at page 0039.

A. I'm sorry, 0029?

Q. 39. I'm sorry.

At the top, at 2.2.2.

A. Yes.

Q. What does this paragraph, 2.2.2 speak to? What concept is it referring to?

A. It's referring to a concept of custodial care, one of the elements of custodial care.

Q. And this requirement states -- am I right? -- (reading):

"Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, even if the specific services are considered to be skilled services, as opposed to improving that function to an extent that might allow for a more independent existence."

Do you see that?

A. I do.

Q. And is that -- do you interpret that to be part of the definition of custodial care?

A. I do.

Q. And in 2015, do you know whether or not the UBH health plans contained a definition of custodial care?

A. They did.

Q. And did they?
A. They did.
Q. Now, directing your attention to Exhibit 10, at page 0002. Starting at page 0002. Exhibit 10. It will be at the front of your book. Probably the very front.
A. I can look at the screen.
Q. Okay. Do you recognize this document?
A. I do.
Q. What is it?
A. It's the Coverage Determination Guidelines' custodial care and inpatient services criteria.
Q. Now, directing your attention to the section on 0003, that starts with "Key Points."

Do you see that?

A. I do.
Q. Down to the third bullet point, it reads:

> "United Behavioral Health maintains that treatment of a behavioral health condition in an acute inpatient unit, or RTC, is not for the purpose of providing custodial care, but is for active treatment of a behavioral health condition."

Do you see that?

A. I do.
Q. In essence, what does that mean?
A. It means that custodial care is an excluded benefit.

Q. And then down to the -- okay. Now, I want to direct your attention to Exhibit 108.

Let me ask one more question about that. Do you have an understanding as to whether, in 2010, UBH health plans defined custodial care?

A. In 2010?

Q. Yes.

A. Yes, they did.

Q. And did they?

A. They did.

Q. Now, directing your attention to Exhibit 108, and specifically to page -- well, we'll start with page 0002. Do you have that in front of you?

A. I do.

Q. Do you recognize that document?

A. I do.

Q. What is it?

A. It's the Coverage Determination Guideline custodial care and inpatient and residential services criteria.

Q. Okay. And then turning, then, to page 0003 in the shaded area of key points. Do you see that?

A. I do.

Q. I want to direct your attention to the fourth bullet point. Do you have that in front of you?

A. I do.

Q. And the fourth bullet point reads (reading):

"The provision of custodial care by trained behavioral health personnel, such as a psychiatrist or licensed clinician, does not cause the services to be classified as skilled services. If the nature of the services can be safely and effectively performed by a nontrained person, the services will be considered custodial care."

Do you see that?

A. I do.

Q. And is that point consistent with generally accepted standards of care?

A. It is.

Q. Why is that?

A. Custodial care is a universal concept really primarily defined by CMS or Center for Medicare Services and it's directed by the plan documents.

Q. Now directing your attention to the fifth bullet point right under it, it starts (reading):

"Active treatment in an inpatient or residential treatment setting is a clinical process involving the 24-hour care of members that includes assessment, diagnosis, intervention, evaluation of care, a treatment and planning for discharge and aftercare under the direction of a psychiatrist."

Do you see that?
A. I do.
Q. And is this provision in your opinion consistent with generally accepted standards of care for a placement in a residential or inpatient setting?
A. It is.
Q. Why is that?
A. Again, it's looking at medical necessity of treatment, describing definition of "active treatment."
Q. When you say "medical necessity," what do you mean?
A. That the treatment is driven by a need for prevention, assessment, diagnosis, intervention, evaluation, treatment planning, et cetera; that the focus of treatment is that.
Q. Okay. And then, finally, directing your attention to Exhibit 195-0003.
A. (Witness examines document.)
Q. Do you have that in front of you?
A. I do.
Q. Do you recognize what is on -- well, first of all, do you recognize Trial Exhibit 195?
A. Yes. It's the Coverage Determination Guideline for custodial care and inpatient and residential services.
Q. Now, directing your attention to 0003, the fourth black bullet point. Do you see that?
A. I do.

Q. Where it starts with "Improvement"?

A. Yes.

Q. It states (reading):

"Improvement of the member's condition is indicated by the reduction or control of the acute symptoms that necessitated hospitalization or residential treatment."

And then it has a subpoint, which states -- I left out the citation, but it has a subpoint that states (reading):

"Improvement is measured by weighing the effectiveness of treatment and the risk that the member's condition would deteriorate or relapse if inpatient or residential treatment were to be discontinued."

Do you see that?

A. I do.

Q. In your opinion, are these provisions regarding improvement consistent with generally accepted standards of care for residential and inpatient services?

A. It is.

Q. Why is that?

A. You know, from a perspective of a clinician, this is what I'm accountable to to my patients. From a perspective of my medical director role, this is the very definition of "improvement," and it's a complex definition that not only includes symptom improvement but is looking at the impact of the level of care to your symptoms.

Q. In your view, does it overly focus on acuity?

A. It does not.

Q. Changing topics now, are you familiar with someone named Gerald Shulman?

A. I am.

Q. Who is Mr. Shulman?

A. Mr. Shulman is one of the editors of the ASAM criteria. He also headed the group that finalized the residential treatment for the ASAM criteria.

Q. In 2013-2014, did UBH hire Mr. Shulman?

A. They did.

Q. As a consultant?

A. They did.

Q. For the purpose of doing what?

A. He was to review the Level of Care Guidelines and the Coverage Determination Guidelines and determine -- and actually give us feedback on the consistency of the Level of Care Guidelines and Coverage Determination Guidelines with ASAM criteria. He was to align the criteria with the *DSM-5* and give us feedback around our criteria.

Q. Was it a comparison between the 2000 -- was it looking at the 2013 Level of Care Guidelines and Coverage Determination Guidelines?

A. Yes.

Q. And was it comparing it to the new and current -- then new

and now current edition of the ASAM criteria?

A. Yes.

Q. The same ASAM criteria as we have at Exhibit 662?

A. Yes.

Q. And did Mr. Shulman complete that project?

A. He did.

Q. And do you know whether he provided suggestions to UBH with respect to changes in its guidelines?

A. He did.

Q. Do you know what a Crosswalk is?

A. I do.

Q. What is a Crosswalk?

A. It's essentially a lineup of our criteria next to the ASAM criteria to allow sort of a back and forth, some matching, you know.

Q. Did he create a Crosswalk as well?

A. He did.

Q. As part of his work product, do you recall whether or not Mr. Shulman provided a redline of UBH's Level of Care Guidelines and Coverage Determination Guidelines?

A. He did.

Q. And did you have an understanding as to whether or not that redline included Mr. Shulman's suggested changes?

A. It did.

Q. Directing your attention to what has been marked as

Exhibit 412 for identification.

A. (Witness examines document.)

Q. Would you page through this document, please.

A. I have.

Q. Okay. Do you recognize the documents contained in Exhibit 412?

A. I do.

Q. What generally are contained in Exhibit 412?

A. It's the contractual agreement that Mr. Shulman signed, and then there's a Crosswalk and the -- sort of the redlined Level of Care Guidelines, as well as the Coverage Determination Guidelines.

Q. And does the redline -- on what page does the redline begin, Doctor?

A. It begins on page 0016 -- or 15, let's say.

MR. RUTHERFORD: Your Honor, we'd move to admit Exhibit 412 into evidence.

MR. GOELMAN: No objection beyond those previously articulated.

THE COURT: There wasn't an objection to this. This is the redline. You didn't object to the redline.

MR. GOELMAN: I think we objected to any iteration of the Shulman report originally.

THE COURT: All right. It's admitted.

(Trial Exhibit 412 received in evidence)

BY MR. RUTHERFORD:

Q. Dr. Alam, did you understand that all of Mr. Shulman's suggested changes were included in the redline that he provided to UBH with respect to the differences between the UBH guidelines and the ASAM criteria?

A. I'm sorry. Your question is whether they were --

Q. Yeah. Did you understand that all of Mr. Shulman's suggested changes and, you know, points of difference were contained in the redline --

A. Yes.

Q. -- that he provided?

A. Yes.

Q. And except for the redlines, the redlined suggested changes that he made, did you understand that the 2013 Level of Care Guidelines and Coverage Determination Guidelines were otherwise consistent with the ASAM criteria?

MR. GOELMAN: Objection. Foundation.

THE WITNESS: Yes.

THE COURT: Overruled.

MR. RUTHERFORD: One moment, Your Honor.

THE COURT: Yes.

(Pause in proceedings.)

MR. RUTHERFORD: No further questions, Your Honor.

THE COURT: Cross-examination.

\\\

CROSS-EXAMINATION

BY MR. GOELMAN:

Q. Good morning.

A. Good morning.

Q. My first question is a real easy one.

THE COURT: Wait a minute. Don't start yet.

(Pause in proceedings.)

THE COURT: Okay. Now proceed.

MR. GOELMAN: Thank you.

Q. My first question is an easy one. Is it Dr. Alam or Alam?

A. Alam.

Q. Alam, okay.

Dr. Alam, is it fair to say that the ASAM criteria is the most widely recognized iteration of generally accepted standards of care for the treatment of SUD?

A. It is.

Q. And also fair to say that a majority of providers have adopted ASAM?

A. That's true in the states where by legislation it's required; but in general, it is really provider-specific criteria so, yes.

Q. And Illinois is one of the states in which ASAM is required by law?

A. It is.

Q. You can't get a license in Illinois unless you know the

ASAM criteria?

A. That's correct.

Q. And you personally supported the law making ASAM use mandatory in Illinois, did you not?

A. I did.

Q. And before Dr. -- I'm sorry -- Mr. Shulman was hired in 2013, were you aware that some within UBH wanted to adopt ASAM as UBH's standard criteria for substance abuse?

A. Yes.

Q. And before 2013 it had not been done; true?

A. That's true.

Q. Okay. I want to show you what's been marked for identification Exhibit 382, and I'm going to ask you a couple questions.

First of all, do you recognize this?

A. (Witness examines document.)

Q. And you're the first listed recipient on that e-mail? I'm sorry. You can look on your screen if it's easier, Doctor.

A. Okay. All right.

(Witness examines document.) I am.

Q. And you recognize this as a cover e-mail to the meeting agenda and minutes of something called the SUDS Clinical Protocols and Policy Meeting?

A. I do.

Q. Okay. And what is the SUDS Clinical Protocols and Policy

Meeting?

A. It was a group put together to -- to review clinical policies and protocols.

Q. And were you part of that group?

A. I was.

Q. Were you actually the head of that group?

A. I was.

MR. GOELMAN: We offer Exhibit 382, Your Honor.

MR. RUTHERFORD: No objection, Your Honor.

THE COURT: It's admitted.

(Trial Exhibit 382 received in evidence)

BY MR. GOELMAN:

Q. Can you turn to page with Bates stamp 0003, please.

A. (Witness examines document.)

Q. And if you would focus on the -- let's see, under "Discussion."

A. (Witness examines document.)

Q. It says (reading):

"CT may have already passed legislation and requires."

Do you see that?

A. Yes.

Q. And it says (reading):

"Will allow us to look at impacts to commercial."

A. Yes.

Q. And is that a reference to the State of Connecticut passing legislation that required the use of ASAM?

A. Yes.

Q. And then it says down below (reading):

"Cost analysis impact on UM in process."

Do you see that?

A. I do.

Q. It says (reading):

"Concern from leaders that we give due diligence in an attempt to determine if any ben-ex impact."

Do you see that?

A. I do.

Q. And is that a reference to a concern by executives at UBH that adopting ASAM would lead to an effect on the benefit expense?

A. I think the impact, if any, was important there better or worse. So knowledge of the impact was, I think, more important.

Q. Okay. Do you remember which leaders in particular were concerned about the ben-ex impact?

A. I don't.

Q. And what kind of due diligence was supposed to be performed on the potential ben-ex impact of adopting ASAM?

A. I suppose looking at current or, at that time, the ben-ex at that time.

Q. Okay. And up above where it says "Will allow us to look at impact commercial," do you see that?

A. I do.

Q. Do you remember what the discussion was around that particular point about Connecticut's legislation allowing a look at the impact on commercial?

A. I do not remember the discussion.

Q. Okay. Reference to "commercial," you understand that to be the commercial side of the business as opposed to the government side of the business?

A. I do.

Q. And the second bullet point says -- it talks about Jerry Shulman. Do you see that?

A. I do.

Q. Is that the same Jerry Shulman that you testified about on direct examination?

A. Yes.

Q. And as you testified on direct examination, in -- what was it, in the fall of 2013 UBH actually hired Mr. Shulman?

A. Yeah, about that time.

Q. Can you take a look at what's already in evidence as Exhibit 1033, please.

A. (Witness examines document.)

Q. And is that an e-mail chain from Dr. Robinson-Beale dated January 1st, 2014?

A. It is.

Q. And you're one of the recipients of that?

A. I am.

Q. Okay. And can you turn now to -- and that e-mail attaches a number of documents; correct?

A. It does.

Q. Okay. Can you turn to 0002 of that exhibit, please.

A. (Witness examines document.)

Q. And that's an e-mail from Mr. Shulman to you and Dr. Robinson-Beale; correct?

A. It is.

Q. Sent on December 20th of 2013?

A. It is.

Q. And can you turn to (reading):

"Please find attached in no particular order 15 files of Optum criteria sent to me. 16 were sent but one was a duplicate."

Do you see that?

A. I do.

Q. You're the one who sent Mr. Shulman those files; correct?

A. I do not recall at this time.

Q. Okay. Do you recall that the files that he was sent included various CDGs of Optum that applied to SUD?

A. Yes.

Q. And he was not sent any mental health CDGs; true?

A. I don't believe so.

Q. And he was not sent any of the benefit plans that Optum administered; right?

A. Not to my knowledge.

Q. So to your knowledge he never saw a Certificate of Coverage; right?

A. Yes.

Q. Okay. And then, Dr. -- I'm sorry -- Mr. Shulman -- I keep doing that -- writes that he's "including four files I have assisted to assist in the process, e.g., ASAM Optum Crosswalk"?

A. Yes.

Q. And that's -- you identified earlier what a Crosswalk was. And he writes (reading):

> "I suggest that you review the four original documents first as will make my edited criteria clearer. I converted the PDF files to word, which I then edited using track changes so that you could see the original copy and any changes that I made. I also added comments when appropriate."

And you understand the reference to "track changes" being part of the Microsoft Word program?

A. I do.

Q. And that allows you to see what changes someone makes to a document?

A. Yes.

Q. And comments are also things that the person who's making changes can insert; is that right?

A. Yes.

Q. And you can see that if track changes is turned on; correct?

A. You could.

Q. But if track changes is turned off, you can't see it; correct?

A. Yes.

Q. Let us turn to Exhibit 412. Wait.

Actually, before that, if you could just look at 1033. There are no -- there are no track changes in those versions of Mr. Shulman's report; correct?

A. (Witness examines document.) I'm sorry. That's exhibit?

Q. 1033. I believe you -- is it not up there?

A. It's not up there.

Q. Okay. You know what? I'll withdraw the question.

A. Okay.

Q. You and Dr. Robinson-Beale were both on this e-mail; correct?

A. Yes.

Q. And when you got the e-mail, did you open up and look at the files that were attached?

A. I don't recall.

Q. I'm not talking about immediately, but at some point did

you?

A. At some point, yes.

Q. And you were able to see Mr. Shulman's comments and markup using track changes; correct?

A. Yes.

Q. And Dr. Robinson-Beale got the same attachments as you did; right?

A. Yes.

Q. So she would have been able to do that too; correct?

A. Yes.

Q. Let's turn back to Trial Exhibit 412.

A. (Witness examines document.)

Q. So when you -- when you first looked at the report that Mr. Shulman submitted to you using track changes, it contained a large number of changes that he suggested; true?

A. Yes.

Q. And some of them were minor; right?

A. Yes.

Q. Some of them were quite substantive?

A. Yes.

Q. Okay. Let's turn to the Crosswalk, which I think is Exhibit 412, page 0013.

A. (Witness examines document.)

Q. And was the purpose of this Crosswalk to make it easier to see the differences and similarities between ASAM and Optum's

guidelines?

A. That was one reason, yes.

Q. Okay. And there's, I don't know, 16 different categories here?

A. Yes.

Q. Okay. And I believe four of them, the third and then the ninth, tenth, and eleventh all say "Optum" -- under "Optum Guidelines," "Not an Optum plan benefit"; correct?

A. Yes.

Q. And the last three of those on the ASAM criteria side list Level 3.1, Level 3.3, and Level 3.5; right?

A. Yes.

Q. And those are the lower residential treatment criteria under ASAM; correct?

A. Correct.

Q. Do you recall getting a phone call from Mr. Shulman shortly after he was retained where he wanted to know where the Optum guidelines for Levels 3.1 to 3.5 were?

A. Yes.

Q. Okay. And you told him that the plans that UBH administered didn't cover those levels; true?

A. I don't recall the conversation but possibly at that time, yes.

Q. Okay. Well, in any case, this Crosswalk is accurate in that ASAM levels of treatment 3.1, 3.3, and 3.5 were not

covered by Optum; correct?

A. Correct.

Q. And Mr. Shulman, among the changes that he recommended, recommended that this change; true?

A. True.

Q. He recommended that Optum begin to cover Level 3.5; right?

A. Yes.

Q. And he recommended that Optum begin to cover Level 3.3; correct?

A. Correct.

Q. I want to ask you a couple questions about the different levels of residential treatment under ASAM.

First, on direct examination you've repeatedly referred to residential treatment as 24-hour confinement. Do you recall that?

A. I do.

Q. Is it your understanding that under the ASAM criteria, all the levels of residential treatment require 24-hour confinement?

A. It's 24-hour care. All the levels require a 24-hour setting.

Q. Okay. Would you agree with me that "confinement" means you can't leave?

A. "Confinement" could have those limitations in some cases, but -- but you have to stay in a facility. So "confinement"

from that perspective. So I use the term more broadly, yes.

Q. Okay. I understood the meaning of the word "confinement" in English. It means that you're unable to leave; true?

A. In general, true.

Q. And the ASAM criteria, even a 3.7 level is not a locked-down prison; true?

A. That's true.

Q. If you're a patient in a 3.7 facility, you can get up and walk out if you want; right?

A. Not in all facilities. So that concept is --

THE COURT: This is not useful. This is a waste of time. Move on to a different subject. He meant it -- he didn't mean that the people were locked down in a residential facility.

MR. GOELMAN: Yes, Your Honor.

Q. Is it your understanding that the criteria for ASAM levels 3.3 and 3.5 are the same as Level 3.7?

A. They are not.

Q. And under the UBH guidelines, if -- actually, you know what? Let me turn first to -- back to 412, and I want to look at residential care guideline there in the redlined version. I think it's 412-0093.

A. (Witness examines document.)

Q. Is that the 2013 Level of Care Guidelines SUD Residential Rehabilitation?

A. It is.
Q. And do you see the blue parenthetical there, "ASAM Level 3.7"?
A. Yes.
Q. And that was added by Mr. Shulman; correct?
A. It was.
Q. And that reflected his belief that this criteria corresponded to 3.7 in particular; correct?
A. Correct.
Q. And not to 3.5 or 3.3; right?
A. Yes.
Q. And the use of guidelines at UBH is mandatory; right? It's not optional?
A. From the perspective that they support clinical judgment, yes.
Q. Okay. Is there anything in the guidelines for residential treatment that suggests that a care advocate can ignore the requirements and allow treatment for a less -- allow treatment where they are not met?
A. There is not.
Q. And I want to -- I want to ask you about something you said on direct about UBH contracting with 3.5 providers.
MR. GOELMAN: Will you hold on one second, please.
(Pause in proceedings.)
\\\

BY MR. GOELMAN:

Q. You wrote an expert report in this case, did you not, sir?

A. I did.

Q. Okay. Do you have a copy of it up there?

MR. GOELMAN: Can we get him a copy?

Can you put 891 up on the screen, please, page 12, Footnote 36.

Q. This footnote says (reading):

"Mr. Shulman suggested that UBH provide coverage for certain levels of care as outlined in the ASAM criteria, such as Level 3.3 and Level 3.5, as these levels of care may theoretically" -- "may be theoretically appropriate for some patients. However, from a practical standpoint, whether UBH provides coverage or not depends on the availability of level of care" -- "the level of care of residential facilities. In my experience, very few facilities, if any, provide these levels of care. As a result, they do not contract for these levels of care with UBH and providers do not request these levels of care for patients at those facilities."

Do you see that?

A. I do.

Q. Is that true that Level 3.3 and 3.5 providers do not contract for these levels of care with UBH?

A. Not as many as we would like.

THE COURT: So what you're saying is that footnote's false? Few, if any?

THE WITNESS: So --

THE COURT: I mean, you just told us that you contracted with people specifically for Level 3.5 facilities. It's not correct to leave the implication in that footnote that there may be no 3.5 level of care facilities that you contract with; right? You overstated in the footnote, let me put it gently.

THE WITNESS: Probably did.

THE COURT: Okay.

BY MR. GOELMAN:

Q. All right. Dr. Alam, we saw before that Mr. Shulman wrote "ASAM Level 3.7" on the top of the residential treatment.

A. I did.

Q. You saw that; right?

I know that you have experience in ASAM. Is it fair to say that Mr. Shulman is more of an expert in ASAM than you are?

A. Yes.

Q. And is it fair to say that Dr. Mark Fishman is also more of an expert in ASAM than you are?

A. I would concede, yes.

Q. Can we look at Exhibit 402 in evidence, please, at 0005.

A. (Witness examines document.)

Q. Do you recognize this as a Crosswalk that was provided to

the State of Connecticut in 2013 to respond to the inquiries about residential care from the Connecticut authorities?

A. I do.

Q. And you were involved in the -- in putting together that response, were you not?

A. I don't recall.

Q. Okay. Well, let me focus you on a particular box that deals with the ASAM criteria under "Residential Care." It's at the bottom there it says (reading):

"Optum guidelines do not identify three separate levels of residential treatment as does ASAM."

That's true; right?

A. Yes.

Q. (reading)

"ASAM levels 3.1, 3.3, and 3.5 are considered residential rehabilitation by Optum."

Do you see that?

A. Yes.

Q. And then it says (reading):

"However, the criteria for all three ASAM levels are included in the admission criteria for residential rehabilitation."

Do you see that?

A. I do.

Q. That's not true; right?

A. So the last point you're checking whether it's true or not?

Q. Right. Is it true that ASAM's residential rehabilitation guidelines provided or included criteria for all three ASAM levels?

A. It is true.

Q. But we just saw that Mr. Shulman labeled it 3.7; correct?

A. That was his recommendation to label our current criteria 3.7 and then include 3.5 and other levels of the residential care.

Q. And didn't we just see a Crosswalk that had 3.1, 3.3, 3.5 not an Optum benefit?

A. I think that in his opinion, there is no benefit, but he had not seen a benefit plan so he was commenting on a benefit plan. So --

THE COURT: You told him there was no benefit.

THE WITNESS: I told him there was no criteria, specific criteria, for it, so...

BY MR. GOELMAN:

Q. Right. And this says the criteria from all three ASAM levels are included in the admission criteria for residential rehabilitation; right?

A. Yes.

Q. That's not true; right?

A. Well, the way we practice it, as I said, there are

facilities that provide 3.5 residential exclusively that are in that work; and, you know, we would use our current criteria to manage patients at those facilities.

Q. Okay. But the words, the words that were in the residential treatment criteria for admissibility, they did not cover ASAM 3.1, 3.3, and 3.5; right?

A. It can be argued that way, yes.

Q. Okay. Did you know that this is what UBH was telling its regulators in Connecticut in 2013?

A. I did not. I was not involved in this, so...

Q. Can you bring up Exhibit 506 in evidence, please.

A. (Witness examines document.)

Q. And this is an e-mail from November 6, 2015; correct?

A. (Witness examines document.) It is.

Q. And the subject is "Follow-up for the CT DOI." Do you see that?

A. I do.

Q. Okay. Can you turn to page 0005, please.

A. (Witness examines document.)

Q. Do you see the same language is contained in these boxes (reading):

> "Criteria from all three ASAM levels are included in the admission criteria for residential rehabilitation"?

A. Yes.

Q. To your knowledge has UBH ever told the State of

Connecticut the truth about its residential treatment criteria?

A. I don't know.

Q. Let's go back to 412 and look at some of the other changes that Mr. Shulman recommended. Okay?

I want to refer you to 412-00 -- sorry -- 0036.

A. (Witness examines document.)

Q. Can you go back to the beginning of the section so we can at least be oriented? I think it's the "Residential Rehab Admission Criteria."

Next. Sorry. Next page. Next page.

Okay. Do you see that at the bottom, it says "Residential Rehabilitation Admission Criteria"?

A. I do.

Q. Okay. And this -- yeah, now can you go to 36, please.

You know, I'm sorry, let's stick with 31 for now. Okay? 31.

The blue, that indicates that it's track changes; correct?

A. It is.

Q. And you see on the side it says "Deleted"? It's got a bunch of things that Mr. Shulman deleted; right?

A. Yes.

Q. And then a bunch of things that he added; right?

A. Yes.

Q. And one of the things that he added, the second bullet point, is:

"The member must meet specifications in at least two of the ASAM six dimensions."

Right?

A. Yes.

Q. This was a change that Mr. Shulman recommended that UBH make; correct?

A. He did.

Q. And it would have made the UBH residential treatment criteria less restrictive; right?

A. Actually, in my opinion, using the ASAM criteria would make the UBH criteria more restrictive.

Q. I'm not talking about in general. I'm talking about taking out the language that was there and requiring that the member must meet specifications in at least two of the six dimensions. That would have made the criteria less restrictive; correct?

A. No.

Q. No.

Okay. Can you turn to 412-0036, please.

A. (Witness examines document.)

Q. Would that change have made the UBH criteria more consistent with ASAM?

A. Possibly.

Q. Well, doesn't ASAM also require meeting only two of six dimensions for admission to residential treatment?

A. That's true.

Q. This is the continued stay criteria for all levels of care; right?

A. Yes.

Q. So you understand that applies not just to residential but also IOP and OP and the others; right?

A. Yes.

Q. Okay. And Mr. Shulman adds the word "or" to this list, and then writes (reading):

> "The member is not yet making progress but has the capacity to resolve his or her problems and is actively working toward the goals articulated in the individualized treatment plan."
>
> Do you see that?

A. I do.

Q. And he adds another one (reading):

> "New problems have arisen which can only be treated safely at this level of care."
>
> Do you see that?

A. I do.

Q. And because he uses the word "or," Mr. Shulman is broadening the pathways to treatment here; right?

A. I don't agree with that.

Q. You don't?

A. I don't.

Q. Isn't he providing a separate way into residential treatment for people?

A. I think that that was one way of looking at it, but it's just changing words so I don't really agree with that concept because I...

Q. When you say "just changing words," you'd agree with me that the words in the criteria matter; right?

A. Yes, they do.

Q. And they affect how the people who work for UBH make determinations whether or not to cover people's health benefits; right?

A. Right.

Q. Okay. So the preexisting bullet point here was (reading):

"The admission criteria is still met and the member is making progress in addressing the admission criteria."

Right? That was already there; correct?

A. Yes.

Q. And he adds a couple other alternatives; right?

A. Yes.

Q. And one of them is "The member is not yet making progress..."; right?

A. Yes.

Q. "... but has the capacity to resolve his or her problems and is actively working toward the goals"; right?

A. Right.

Q. And another one is "New problems have arisen which can only be treated safely at this level of care"; right?

A. Right.

Q. And those are other alternatives that would allow somebody to be approved for continued stay criteria; right?

A. There are other alternatives, yes.

Q. Okay. But you don't agree that Mr. Shulman's suggestions would have, if they were adopted, made the guidelines less restrictive?

A. I don't agree with that.

Q. Okay. So Mr. Shulman submits to you his changes, and UBH reviewed it; correct?

A. Yes.

Q. And they considered them; right?

A. Yes.

Q. Was the group that was assigned the job of evaluating Mr. Shulman's provisions SUD Team 2?

A. It was.

Q. And were you the leader of SUD Team 2?

A. I was.

Q. Okay. Can you take a look at Exhibit 420, please.

A. (Witness examines document.)

Q. And that is an e-mail from Dr. Robinson-Beale; correct?

A. Yes.

Q. To a list of recipients and it talks about "Jerry and SUD

Team 2 will review and flush out the comments from Jerry"; correct?

A. Yes.

Q. Okay. Is this 002? Would you turn to page 2 of this exhibit, please.

A. (Witness examines document.)

Q. That is page 2? Okay. Great.

Why -- do you know why SUD Team 2 was chosen for this role?

A. I don't.

Q. Okay. Is SUD Team 2 considered subject matter experts on the use of ASAM?

A. Yes.

Q. Could that have been the reason that it was chosen?

A. Yes.

Q. And did you --

MR. GOELMAN: First, we offer Exhibit 420, Your Honor.

MR. RUTHERFORD: No objection, Your Honor.

THE COURT: It's admitted.

(Trial Exhibit 420 received in evidence)

BY MR. GOELMAN:

Q. How did SUD Team 2 go about considering whether or not to implement Mr. Shulman's recommendations?

A. By making the recommendations, I believe, that ASAM be adopted.

Q. That was the conclusion; correct?

A. That was the conclusion.

Q. But in the process, did you have a meeting and discuss the recommendations?

A. Right. We probably had several meetings.

Q. Okay. And the conclusion of that was that the team decided to recommend that UBH adopt ASAM as the criteria; correct?

A. Yes.

Q. Did anyone on the SUD team disagree with that conclusion?

A. Not that I recall.

Q. Okay. So as far as you remember, it was unanimous among the subject matter experts?

A. Yes.

Q. Okay. And you personally agreed with that; correct?

A. I did.

Q. And then that recommendation was brought before the committee called BPAC for its consideration and decision; right?

A. I don't recall that part actually.

Q. Okay. Can you turn to Exhibit 421, please, page 12.

A. (Witness examines document.)

Q. This is a PowerPoint entitled "Is it time to adopt ASAM criteria as SUD guidelines? BPAC February 2014." Do you see that?

A. I do.

Q. And does that indicate that your committee's recommendation was to consider it at the BPAC meeting in February 2014?

A. I think we were preparing to go to BPAC, but I -- this is still in preparation. I don't believe we went to BPAC at that time. I don't recall. I mean, I -- yeah, at least I don't recall.

Q. Okay. Can you turn to page 13, please.

A. (Witness examines document.)

Q. It says (reading):

"SUDS Team 2 is proposing that OptumHealth use ASAM guidelines for utilization management."

Do you see that?

A. I do.

Q. And that's an accurate portrayal of what your committee's recommendation was; right?

A. It is.

MR. GOELMAN: Okay. We offer Exhibit 421, Your Honor.

MR. RUTHERFORD: No objection.

THE COURT: It's admitted.

(Trial Exhibit 421 received in evidence)

BY MR. GOELMAN:

Q. Can you turn to page 14, please.

A. (Witness examines document.)

Q. This says (reading):

"ASAM criteria is used in most plans in over 30 states."

Right?

A. Yes.

Q. That's true; right?

A. It is.

Q. (reading)

"Most other providers use ASAM criteria."

Right?

A. Yes.

Q. That's also accurate; correct?

A. Yes.

Q. And then (reading):

"A strong consideration to adopt ASAM guidelines should be made considering the current healthcare climate."

Do you see that?

A. I do.

Q. And do you know what is referred to when reference is made to "the current healthcare climate"?

A. Really sort of a number of states were looking at adopting ASAM.

Q. Okay. It says (reading):

"Community is demanding more neutrality. Add points

from e-mail, Conn. law, Danesh reviewing."

Do you see that?

A. I do.

Q. What does it mean when it says "community is demanding more neutrality"?

A. In terms of criteria, that they want more sort of neutral criteria.

Q. Do you understand "community" being the SUDS treating community?

A. Yes.

Q. And they thought that the UBH criteria were not sufficiently neutral?

A. Not -- I don't agree with that.

Q. I'm not asking if that's your opinion. That was the community's opinion; right?

A. In this instance, yes.

Q. Okay. And when it says "Conn. law, Danesh reviewing" -- do you see that?

A. I do.

Q. -- do you understand that reference?

A. I do.

Q. And you're Danesh; right? You're the only Danesh on the SUDS committee?

A. I am, yes.

Q. So were you reviewing Connecticut law for some reason?

A. I was not reviewing -- well, I was reviewing what was going on in Connecticut. It was still sort of developing.

Q. Okay. And what was your assignment with regard to Connecticut law?

A. Well, it was to find out if Connecticut is moving towards, you know, adapting ASAM.

Q. Okay. And what did you find out?

A. That they were.

Q. Can you turn to 0015, please.

A. (Witness examines document.)

Q. This is under the title "Challenges"; correct?

A. Yes.

Q. The second bullet point it says (reading):

"What would the impact be on our utilization?"

Do you see that?

A. I do.

Q. And do you understand the reference to "utilization" being a reference to utilization of care?

A. Yes.

Q. Of benefits?

A. Yes.

Q. Okay. Does this reflect a concern about whether UBH's ben-ex would increase if UBH adopted ASAM?

A. Not just increase. Whether there would be a change is more important.

Q. Well, UBH wouldn't be concerned if the change was that ben-ex would decrease, would it?

A. It would be of interest, absolutely.

Q. But it wouldn't be a challenge; right? It would be a benefit.

A. Yeah.

Q. Can you turn to the next page, please.

A. (Witness examines document.)

Q. It says "Benefits to Adopting ASAM"; right?

A. Yes.

Q. I just want to ask you a question about the last bullet point there. It says (reading):

"Using nationally recognized criteria would provide a degree of legitimacy."

Do you see that?

A. Uh-huh.

Q. And was there a sense, in the provider community at least, that the UBH's guidelines as they were written were not particularly legitimate?

A. I wouldn't agree with that.

Q. You wouldn't. Okay.

Could you turn to the next page, please, 17.

A. (Witness examines document.)

Q. It says "ASAM Guideline Limitations." Do you see that?

A. I do.

Q. It says, "Will this increase utilization?" Right?

A. Yes.

Q. And we talked about utilization before. Then it says, "Best case cost savings. Minimum no impact"; right?

A. Yes.

Q. And is that another reflection of the concern that a switch to ASAM might increase ben-ex?

A. It had to be evaluated one way or the other.

Q. Okay. So is that yes?

A. Yes.

Q. Okay. When it says "Minimum no impact," that means that at worst for UBH to switch to ASAM, it had to not increase ben-ex; right?

A. One of the -- yes, one of the possibilities.

Q. Well, "minimum" means if it doesn't meet that criteria, we're not going to adopt it; right?

A. (Witness examines document.) If it -- if it has minimal impact you mean?

Q. No. It says, "Best case cost savings"; right?

A. Right.

Q. "Minimum no impact"; right?

A. Right.

Q. So doesn't this reflect the sentiment that UBH is not going to adopt ASAM unless the worst case scenario is that there's not going to be any impact on ben-ex? Isn't that what

this means?

A. I think it's predicting what the utilization would be and it's actually saying -- win-win both ways is what it's saying.

Q. I see.

Okay. It says, the third bullet point (reading):

"ASAM criteria has multiple levels of care for which we do not currently have guidelines."

Do you see that?

A. I do.

Q. And does that include 3.1, 3.3, and 3.5?

A. Yes.

Q. And why was that considered a limitation of switching to ASAM?

A. You know, as I mentioned before, all the communities don't -- all of the providers don't have all the levels of care.

Q. Right.

A. We have more levels in some instances and ASAM has more levels in others, and so that's a challenge.

Q. Okay. Can you turn to page 19, please, 421-0019. It says "Limitation to the Levels of Care Guidelines." Do you see that?

A. Yes.

Q. You understand that to be a reference of the UBH Level of Care Guidelines as they existed in 2014?

A. Yes.

Q. And it says -- the last bullet point says (reading):

"Perceived as making our own rules for benefits determination."

Do you see that?

A. I do.

Q. What do you understand that to be referring to?

A. Perception that we make our rules around, you know, decisions, medical necessity decisions.

Q. Okay. And does that reflect a perception that UBH made its rules in order to benefit itself and not its members?

A. It could be perceived that way, but it's a perception. Again, we're talking about perception versus reality here, sir.

Q. Right.

Okay. Can you turn to page 20, please.

A. (Witness examines document.)

Q. "Other Stakeholders Implications." It says (reading):

Legal. Feedback from legal. Martin does not want to do this until we know cost information."

Do you see that?

A. I do.

Q. And who's Martin?

A. Martin Rosenzweig is chief medical officer.

Q. Okay. What was your understanding of why Dr. Rosenzweig wanted to refrain from consulting with legal until you knew the

cost information?

A. I don't know why.

Q. He never explained that?

A. No.

Q. Can you put this exhibit to the side for a moment and look at Exhibit 430, please, and 0007.

A. (Witness examines document.)

Q. Is that an e-mail from you to Michael Haberman with the subject "Jerry Shulman" that you sent on February 10th of that year 2014?

A. It is.

Q. And who is Mr. Haberman?

A. He's a regional medical director.

Q. Okay. And you know of him that Jerry charges 350 for one-hour training; correct?

A. Yes.

Q. And is that a reference to Mr. Shulman's rate for a one-hour training?

A. That's correct.

Q. And why did you send Mr. Haberman that e-mail?

A. Because we were looking at Jerry doing some training for our staff.

Q. Okay. Can you turn to 0004, please.

A. (Witness examines document.)

Q. This is an e-mail from Dr. Triana to Dr. Rosenzweig;

right?

A. Yes.

Q. And he says (reading):

"We are placing the cart way in front of the horse."

Right?

A. Right.

Q. (reading)

"Let's see if the ASAM adoption occurs first. I have received e-mails from folks wondering why we are talking about training when the ASAM decision has not been made yet."

Correct?

A. Correct.

Q. And then the third paragraph says (reading):

"Have all the SUDS teams had a chance to review the ASAM recommendation by Team 2? And if so, is there consensus that this is the formal SUDS," quote/unquote, "recommendation."

Do you see that?

A. I do.

Q. (reading)

"If not, I would recommend doing so, otherwise we need to change the dec. to reflect that this is Team 2's recommendation, not all of SUDS."

Do you see that?

A. I do.

Q. And was the recommendation to adopt ASAM the recommendation of all of SUDS and not just SUDS Team 2?

A. I don't recall actually.

Q. Do you recall any of the other SUDS teams voicing a disagreement?

A. I know there was a discussion, but I don't believe that there was a major disagreement.

Q. Okay. Well, let's turn to page 2. There's an e-mail from Dr. Rosenzweig to Dr. Triana and it says (reading):

> "Team 2 is tasked with looking specifically at ASAM versus OHBS and has looked extensively at this. I'm not sure if there is much value to the other teams weighing in here as they do not have the background and at this point would be reviewing a dec. I have added some of the participants and other teams for their input, and I think there is consensus amongst all the addiction psychiatrists that this would be a good idea."

Do you see that?

A. Uh-huh.

Q. Okay.

A. I do.

Q. Dr. Rosenzweig was correct, was he not, that there was consensus among all the addiction psychiatrists at Optum that UBH should move to the ASAM criteria?

A. Yes.

Q. Let's turn to Exhibit 452, please.

A. (Witness examines document.)

Q. And this is an e-mail from the following year -- right? -- June 10th, 2015?

A. (Witness examines document.) It is.

Q. And you're one of the recipients?

A. I am.

Q. And it's attaching a SUDS quarterly update?

A. Yes.

Q. Okay. Can you turn to page 8, 452-0008?

A. (Witness examines document.)

Q. At this point was the team -- oh, I'm sorry. I may have misspoken.

Is this -- turn back to page 1, please.

A. (Witness examines document.)

Q. Okay. This e-mail is from June 2014 -- right? -- not 2015?

A. Yes.

Q. Okay. My mistake.

Can you turn again to page 8, please.

A. (Witness examines document.)

Q. All right. And it says (reading):

"Team 2 clinical protocol. ASAM contingent rollout."

Do you see that?

A. I do.

Q. And you're listed as the team lead?

A. I am.

Q. And was the contingent rollout a proposal to basically stick a toe in the ASAM waters?

A. That's one way of looking at it.

Q. Okay. You were going to start small and see whether or not it had any impact on ben-ex?

A. Well, I wasn't looking at ben-ex. I was looking at the clinical impact of it.

Q. Okay. Under issue it says (reading):

"Currently no utilization/ben-ex data allowing meaningful comparison for ASAM versus OHBS SUDS criteria sets."

Right?

A. Yes.

Q. And so was the point of this contingent rollout so that UBH -- I'm not saying you personally -- could get a sense of whether there was an impact on ben-ex from using ASAM instead of UBH's own guidelines?

A. It's one of the things we would look at.

Q. Okay. The second-to-the-last bullet point says (reading):

"If utilization is same or less for ASAM, continue rollout/expand pilot."

Do you see that?

A. I do.

Q. Does that reflect that if this pilot project reflected that it wasn't causing UBH's ben-ex to go up, then it would be continued; correct?

A. Actually, you know, ASAM criteria came into existence to control ben-ex so that the very first iteration going back in the '80s, the group got together to control ben-ex. So I think just to assume that, ASAM is important to understand the ben-ex; but I think going into it expecting it would be less or more, it may not be fully accurate.

Q. Yeah. I'm actually asking you about this line in this PowerPoint that UBH put together. Okay? It says (reading):

"If utilization is same or less for ASAM, continue rollout/expand pilot."

Do you see that?

A. I do.

Q. And you're listed as the team lead; correct, Doctor?

A. Yes.

Q. And was it your understanding, did this mean that if this pilot program showed that the utilization was the same or less under ASAM, then it would be continued and expanded? Right? That's what this means?

A. That would be a stop and reconsider.

Q. Okay. Can you answer my question now?

A. Yes, that would be one, you know, consequence probably.

Q. Okay. Thank you.

And, conversely, if utilization was more for ASAM, then the rollout would not be continued, would not be expanded, it would be terminated; correct?

A. Yes.

Q. 548, please.

MR. GOELMAN: I'm sorry. Can we offer 452 if we haven't yet?

MR. RUTHERFORD: No objection.

THE COURT: It's admitted.

(Trial Exhibit 452 received in evidence)

BY MR. GOELMAN:

Q. Turn to 548, please.

A. (Witness examines document.)

Q. Now, this is an e-mail to Martha Temple, and this is from July 2016; right?

A. (Witness examines document.) It is.

Q. And Ms. Temple is the head of UBH; correct?

A. Yes.

Q. And was in 2016?

A. Yes.

Q. Can you turn to 0002, please, their ASAM criteria, the fifth -- Number 5 there. It says (reading):

"ASAM Criteria. Martin will be walking us through the journey thus far on transitioning ASAM to be our

standard SUD criteria."

Do you see that?

A. Yes.

Q. (reading)

"He will share the pros, cons, cost impacts, et cetera, and we will make a decision on where we want to go from here."

That's what it says; right?

A. Yes.

Q. Do you understand the reference to "cost impacts" to be a reference to the impact on ben-ex?

A. Yes.

MR. GOELMAN: We offer 548, Your Honor.

MR. RUTHERFORD: No objection, Your Honor.

THE COURT: It's admitted.

(Trial Exhibit 548 received in evidence)

BY MR. GOELMAN:

Q. Let's turn to Exhibit 348.

A. (Witness examines document.)

Q. And this is an e-mail from four years earlier in 2012. Do you see that?

A. I do.

Q. And the subject is "Use of ASAM Criteria Poll"; right?

A. Yes.

Q. All right. Will you turn to 0002, please.

A. (Witness examines document.)

Q. It says (reading):

"While the six dimensions ASAM criteria are helpful in conceptualizing cases and focusing on what they need, use of these criteria usually will result in more authorization as they are more subjective and broader than our Level of Care Guidelines/CDGs."

Do you see that?

A. Yes.

Q. Do you agree that use of ASAM generally usually will result in more authorization?

A. I do not.

MR. RUTHERFORD: I'm sorry, Your Honor. If we could just pause for a moment. I can't seem to find the 348 exhibit.

MR. GOELMAN: Oh.

MS. ROMANO: It's not in our binder.

MR. RUTHERFORD: It's not in our binder.

THE COURT: Let's pause. Is it on the list?

MR. GOELMAN: I thought it was, Your Honor.

MR. RUTHERFORD: I don't know if it's in the binder for this witness.

THE COURT: It is in the binder for this witness.

MR. RUTHERFORD: Okay. If we can --

THE COURT: Sure. Let's make sure you have it.

(Pause in proceedings.)

MR. RUTHERFORD: I don't believe he's a recipient of this.

THE COURT: Okay. Let's just continue with the examination.

MR. RUTHERFORD: Yeah.

BY MR. GOELMAN:

Q. Actually, you'd said that you disagree with the opinion that use of ASAM usually will result in more authorization; correct?

A. I disagree.

Q. You disagree with that.

But are you aware that in 2012, UBH considered adopting ASAM?

A. I am not.

Q. Are you aware that they -- well, we just talked about the consideration in 2014; correct?

A. We did.

Q. And again in 2016, UBH considered adopting ASAM; correct?

A. I'm not aware of the efforts.

Q. Okay. We just saw an e-mail from -- e-mail to Martha Temple dated July 2016; right?

A. I was not a recipient of that e-mail.

Q. Okay. And you had no idea that there was a consideration by UBH of whether or not to adopt ASAM in 2016?

A. No.

Q. Is it true that to this day, UBH has not adopted ASAM?

A. It has adopted ASAM in the states where it's required by legislation.

Q. Okay. In states where it's not legally compelled to adopt ASAM, UBH has not adopted it; right?

A. Yes.

Q. You testified that it's your opinion that UBH's guidelines, substance use guidelines, are consistent with generally accepted standards of care?

A. I have.

Q. I want to ask you a couple questions about that opinion. UBH's guidelines do not contain separate criteria for children and adolescents, do they?

A. They do not.

Q. And there are peer reviews at UBH that are conducted by nonchild psychiatrists; right?

A. Correct.

Q. And you regard -- strike that.

Substance use disorder is a long-term chronic illness, isn't it?

A. The concept that developed in the 21st century, yes.

Q. And is it true that like other chronic illnesses, underreporting is common in addictive disorders?

A. Yes.

Q. Would you agree that choosing appropriate level of care

for substance use disorders is important?

A. Yes.

Q. And that relapse may occur if a less intensive level of care than is appropriate is initiated?

A. One of the possibilities, yes.

Q. On the other hand, is it true that there is no research evidence to the existence of a consequence to choosing a more intensive level of care than necessary?

A. Actually, that is true. That's true, yes, that there's no research saying if you choose a higher level of care, whether it's bad for you. Yes, there's no research.

Q. Okay. And that remaining in treatment for an adequate period is critical for treatment effectiveness? That's true too; right?

A. I would modify that a little bit.

Q. You would modify the statement of remaining in treatment for an adequate period is critical for treatment effectiveness?

A. Treatment engagement irrespective of the level of care --

Q. Uh-huh.

A. -- yes.

Q. What about remaining in treatment for an adequate period, is that critical?

A. It is critical.

Q. Are patients who are unlikely or unable to maintain abstinence, are those a group of patients that could benefit

from residential programs?

A. That's broad. Yes, they could.

Q. And would you agree that the duration of residential treatment should be determined by the clinical response to therapy based on the ASAM criteria?

A. Yes.

Q. And that there is even some evidence that some patients may benefit from -- well, withdrawn.

Is it true that data suggests that individuals who stay in residential treatment at therapeutic communities for 12 to 24 months are more likely to maintain long-term abstinence?

A. I don't agree with that.

Q. You don't agree that data suggests that?

A. I'm not. I've written about it. I would like to review the data, but the data that I have looked at is not -- is not convincing. So there are two areas where research has not been helpful. Lengths of stay, and ASAM criteria does talk about it just in those words.

The second issue is in terms of assessing risk, research has not been helpful. Risk is used to determine the level of care. Research has not been helpful in helping us define the risk needed for each of the levels of care.

Q. Okay. You mentioned that you've written about this. Can you turn to Exhibit 673, please.

A. (Witness examines document.)

THE COURT: So find an appropriate place for us to break.

MR. GOELMAN: Okay.

Q. Can you turn to page 10 of this exhibit, please.

A. (Witness examines document.)

Q. Let's see, where... "In the therapeutic community, transitional living program," do you see that?

A. I do.

Q. The last line in that section says (reading):

"Data suggests that individuals who complete 12 to 24 months at this level of care are more likely to maintain long-term abstinence."

Do you see that?

A. Yes.

Q. And did you and Dr. Martorana include that in your article?

A. We did.

MR. GOELMAN: This is a good place, Your Honor.

THE COURT: All right. So I'll see you all here in an hour.

(Luncheon recess taken at 12:24 p.m.)

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Monday, October 30, 2017 1:31 p.m.

P-R-O-C-E-E-D-I-N-G-S

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THE COURT: Let's proceed.

THE CLERK: So we're back on the record in case number C 14-2346 Wit/Alexander versus UBH.

Mr. Goelman, go ahead.

MR. GOELMAN: Thank you.

Your Honor, after review of the transcript it was revealed I neglected to offer two the exhibits that I asked the witness about: 430 and 348. So we offer them into evidence any.

THE COURT: Any objection?

MR. RUTHERFORD: No objection.

MR. GOELMAN: 348 and 430.

THE CLERK: Thank you.

THE COURT: They are admitted.

(Trial Exhibit 348 and 430 received in evidence.)

MR. GOELMAN: And I don't have any further questions.

THE COURT: Okay. Redirect.

MR. RUTHERFORD: Very briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. RUTHERFORD:

Q. Dr. Alam, directing your attention to Exhibit 506.

Do you have that in front of you?

A. I have.

Q. You're not listed on this email; is that right?

A. Yes, I'm not.

Q. And you didn't see this email prior to this litigation?

A. I did not.

Q. Directing your attention to Exhibit 548.

Dr. Alam, are you a recipient of this email?

A. I am not.

Q. And have you seen this email prior to this litigation?

A. I have not.

Q. And then Exhibit 348.

Are you a recipient of this email, Dr. Alam?

A. I am not.

Q. Okay. And had you seen this email before this litigation?

A. I have not.

MR. RUTHERFORD: No further questions, Your Honor.

THE COURT: Okay. Thank you very much.

THE WITNESS: Thank you.

THE COURT: You may step down.

They'll take care of that.

THE WITNESS: Thank you.

(Witness steps down.)

MR. RUTHERFORD: So, Your Honor, defense is going to call Dr. Lorenzo Triana. Switch out some binders.

And, Your Honor, for this witness, just as everyone is getting settled, there are some sealing issues Mr. Bualat is

going to raise.

THE COURT: Yes, Mr. Bualat. Go ahead.

MR. BUALAT: Thank you, Your Honor.

There are no exhibits on the direct examination, but there are several exhibits on plaintiffs' cross-examination exhibits that raise sealing issues and for which we filed motions either last night or the last couple of weeks.

THE COURT: Yes, I have them.

MR. BUALAT: So the exhibits, the first one is Exhibit 8 -- excuse me, 810.

THE COURT: What's the issue with -- 810, is that going to be used?

MR. ABELSON: Your Honor, I think this is one of the situations where we don't know at this moment.

THE COURT: Okay. You can't rule it out. Got it. 810, yes.

MR. BUALAT: You want me to state the basis, Your Honor?

THE COURT: Yes, please.

MR. BUALAT: 810 reflects legal advice from in-house attorney Adam Easterday. It relates to ABA and the regulatory inquiry. And that one, in fact, there's clear advice from Mr. Easterday relating to those issues.

THE COURT: Okay.

MR. BUALAT: 803 is another email that relates to that

issue.

THE COURT: Okay.

MR. BUALAT: And that is in the motion that we filed yesterday.

THE COURT: Yep, I got that.

MR. BUALAT: There's also Exhibit 552. That is a redaction on one page. It's meeting minutes in which one of the attendees to the meeting relays to the meeting members legal advice.

THE COURT: Uh-huh.

810 and 803 are also just partially redacted?

MR. BUALAT: Yes, Your Honor. Those ones are partially redacted.

THE COURT: Uh-huh.

MR. BUALAT: And if you would like, the pages for 803 is page 2. The pages for 810 is page 1 and 2 have redactions.

THE COURT: Okay.

MR. BUALAT: Exhibit 552, which I mentioned, is that one entry on page 10. Exhibit 458 also has an email that has legal advice. And it's a redaction of page 2, or part of page 2.

THE COURT: Uh-huh.

MR. BUALAT: This one was filed in a motion that we filed last week, on the 22nd. And this exhibit, it's motion 367, and it's Exhibit 349. And that also reflects legal

advice. And I believe that's a partial redaction of that document, Your Honor.

I don't have the page numbers here.

THE COURT: That's okay.

MR. BUALAT: And then the last exhibit on the list, that has not been ruled upon yet, is in motion 361, which was filed on the 17th of October. And the exhibit there is Exhibit 812.

And that one, actually, we sought to seal the entirety of that exhibit. That relates to the ABA Indiana regulatory issue. And that reflects advice from Mr. Easterday on, for instance, page 2. And there's a request of advice from him on page 4. And then the message on page 1 reflects a question about legal advice.

THE COURT: Okay. Can I see 812, please?

MR. BUALAT: It's at the very back.

(Pause)

THE COURT: Who is the lawyer in Exhibit 812?

MR. BUALAT: Adam Easterday, Your Honor. And there's an email, for instance, from him on page 2. I think it's December 15, 2016. And then the initial email is a message directed to him amongst others.

THE COURT: I'm not going to allow that.

You can redact the legal advice that's in there; but a lot of it is not legal advice or in response to legal advice.

There's a lot of discussion about benefit expense in there. And you're not going to be allowed to redact things that's basically business.

So I don't know -- I guess, I don't have a problem with the exhibits being sealed, at least redacted in the fashion you have chosen.

MR. ABELSON: We don't object to the other redactions. We do object to 812 in full.

THE COURT: So I want that redacted. And you can meet and confer on what's appropriate to redact; but only legal advice or references to legal advice or direct seeking of legal advice or indirect seeking of legal advice. Those are the things that get redacted; not "I don't want to make a change because it will impact our ben-ex." Right.

MR. BUALAT: Understood, Your Honor.

One last point is, there are several other exhibits on their list for cross-examination that were subject to the joint motion that the parties filed. I imagine we would just bring that up as they come, to the extent they're used.

THE COURT: Well, it depends what it is. If it's -- if it is the per-member-per-day, then I'm prepared to seal the courtroom for that. I doubt very much they'll be using those.

If it is the -- so what's the others? I guess you had joint motions because of some of the privilege is still preserved because it was the fiduciary exception?

MR. BUALAT: That's correct, Your Honor. And I believe these all fall -- because they are the part of the joint motion would not be the per-member-per-month because there is no agreed-upon sealing of those documents.

THE COURT: Okay. Well, I don't know. What are you going to do with those?

MR. BUALAT: This would be 472, 539, 758, 782, and 814.

MR. ABELSON: These are all subject to the joint motion?

MR. BUALAT: Yes.

MR. ABELSON: If it was subject to the joint motion, we don't --

THE COURT: Well, all I'm saying is, if you are going to use things subject to the joint motion, I am prepared for those, to accommodate that in terms of arranging to seal the courtroom for a very brief period of time, if you're agreeable to doing it. I'm not with respect to something that I think has been waived, which is the other privileges.

MS. REYNOLDS: Your Honor, I think, probably before cross-examination it would be appropriate for us to take a moment and determine if any of those documents are actually going to be used.

THE COURT: Fine. And then you can figure out which end of the examination you want to use them on.

MS. REYNOLDS: Sure.

MR. ABELSON: Your Honor, looking at the docket over the weekend, there are four documents that are denial-letter-related exhibits that we just need to have sealed on the record. The parties have agreed and the Court has already ruled that those can be sealed. Those are exhibits 899, 2033, 2038, and 2039.

THE COURT: Okay. So just to be clear, those are sealed. At least the redactions; right? We're sealing the whole exhibit, or sealing redactions?

MR. ABELSON: We had been sealing the whole denial letter. Chock-full of --

THE COURT: Whatever we have done in the past is fine. The ones you brought up today, the non-joint ones, the redactions are granted. You will meet and confer on the 812 redaction.

MR. ABELSON: Thank you.

MR. BUALAT: Thank you, Your Honor.

THE COURT: Great. Okay. Where were we?

MR. RUTHERFORD: We were where the defense is calling Dr. Lorenzo Triana.

THE COURT: Okay.

THE CLERK: Dr. Triana.

THE WITNESS: Yes, ma'am.

THE CLERK: Please raise your right hand.

LORENZO TRIANA,

called as a witness for the Defendant, having been duly sworn, testified as follows:

THE CLERK: Thank you.

So have a seat. Speak clearly into the microphone. And if you could just spell your last name for the record, please.

THE WITNESS: Yes, Triana, T-r-i-a-n-a.

THE CLERK: Thank you.

DIRECT EXAMINATION

BY MR. RUTHERFORD:

Q. Good afternoon, Dr. Triana.

A. Good afternoon.

Q. Are you a psychiatrist?

A. I am.

Q. In which states are you licensed?

A. I'm licensed in the state of Texas.

Q. Are you board-certified?

A. I am.

Q. In what?

A. In both general and addiction psychiatry.

Q. And do you see patients in private practice?

A. I do.

Q. And have you treated patients for both mental health and substance use disorders in private practice?

A. I have.

Q. And have you treated patients along the entire continuum of care?

A. Yes.

Q. From outpatient to res- -- I mean outpatient to inpatient?

A. Yes.

Q. Now, you testified last week that you're currently the Senior Vice President of Behavioral Medical Operations at UBH?

A. Yes.

Q. How long have you held that position?

A. Since 2010.

Q. And how long have you worked for UBH?

A. Since 2000.

Q. Briefly describe your responsibilities as the senior vice president for behavioral operations.

A. I oversee the activities of the medical directors on the behavioral or operations side of the organization. I participate in committees. And I'm also a member of the senior leadership team for behavioral operations.

Q. Is one of the committees that you've participated in a committee known as the BPAC?

A. Yes.

Q. Is another committee you've participated in a committee known as the Utilization Management Committee?

A. Yes.

Q. Prior to being the senior vice president position, did you

serve as a medical director at UBH?

A. I did.

Q. Out of which part of the country?

A. Dallas.

Q. What was your position?

A. I was a medical director.

Q. And what were your duties as a medical director at UBH?

A. I would be involved in quality and utilization activities, involved in peer reviews, case consultations, committee work, and such.

Q. And are you a member of any professional societies?

A. I am?

Q. Which are those?

A. The American Medical Association, the American Psychiatric Association, the Texas State Psychiatric Physicians Association, and then also the American Academy of Addiction Psychiatry.

Q. Now, you testified last week that UBH creates its own level of care and coverage determination guidelines. Do you recall that generally?

A. Yes.

Q. And that these guidelines are used to make medical necessity and coverage determinations except when required to use other guidelines, like state-specific guidelines; right?

A. Yes.

Q. Has UBH used its own Level of Care Guidelines or Coverage Determination Guidelines since you joined --

A. Yes.

Q. -- UBH?

Do you know why UBH creates its own guidelines?

A. I think there's several reasons why UBH uses its own guidelines.

I think that it allows the company to review those and update those on an annual basis, and allows us to obtain feedback from internal clinicians, external clinicians, and also professional organizations.

It allows us to adjust the guidelines according to what's going on in the network.

And it also helps us reflect the clinical vision regarding recovery and resiliency.

Q. Are you familiar with the process by which the Level of Care Guidelines and Coverage Determination Guidelines were developed, updated, and approved between 2011 and 2017?

A. Yes.

Q. Okay. Starting with the Level of Care Guidelines, were there Level of Care Guidelines in existence when you joined -- let me ask this differently.

When did you join the BPAC?

A. 2010.

Q. Is that when the BPAC was formed?

A. Yes, sir.

Q. In 2010, when the BPAC was formed, was UBH already using Level of Care Guidelines?

A. Yes.

Q. How often are Level of Care Guidelines updated?

A. On a yearly basis.

Q. And at what point in the year would the process of updating a level of care guideline get started?

A. Usually around the third quarter, into the fourth quarter of the year.

Q. How would the process start?

A. It would start with, typically, Jerry Niewenhous and his team conducting research on any updates -- scientific evidence; practice guidelines; regulatory updates -- that may have occurred since the last guideline was updated.

Q. And then once Jerry and his team conduct -- conduct this review, what would happen next?

A. A draft of the Level of Care Guidelines for the following year would be created. And then we would solicit input from clinicians, both internal and external to the company, and also representatives of various professional organizations as well.

Q. When you say internal clinicians of the company were solicited, what level of degree did those clinicians generally hold?

A. It was typically our medical doctors, Ph.Ds, and

masters-level education as well.

Q. Directing your attention to Exhibit 1235.

Do you recognize this document?

A. I do.

Q. What is it?

A. This is -- this is a copy of individuals whose feedback we solicited for the guidelines, for the 2016 guidelines.

Q. On page 1235-0001, does that indicate -- where it says "staff," is that the same thing as your internal clinicians?

A. Yes.

Q. And then what does it show on page 1235-0002?

A. Indicates the individuals outside of the organization that were also asked to provide some input.

MR. RUTHERFORD: Would move to admit Exhibit 1235 into evidence, Your Honor.

MR. KRAVITZ: No objection.

THE COURT: It's admitted.

(Trial Exhibit 1245 received in evidence.)

BY MR. RUTHERFORD:

Q. Dr. Triana, is this list of Optum staff consistent with the Optum staff that would receive the solicitation each year for input on the Level of Care Guidelines?

A. Yes.

Q. Now, turning to page -- and that was from 2011 to, what, 2017?

A. Yes.

Q. Turning the page to Trial Exhibit 1235-0002, what is this list on this second -- on the second page?

A. Again, this is a list of a combination of individual providers and/or representatives of some of the professional organizations.

Q. Do you recall your testimony last week regarding an entity called the BSAC?

A. Yes.

Q. Would -- well, let me ask this: Where -- what connection, if any, do these providers, these external clinicians, have to UBH?

A. So if they're providers, they would be treating our members. So they're part of the provider network. Some of these individuals would be a member, maybe, of the BSAC. But that would be the relationship.

Q. And do these represent providers who are affiliated with -- at least in part, affiliated with the BSAC?

A. Yes. Several of these are.

Q. Are you familiar with an entity called the NPAC?

A. Yes.

Q. What is the NPAC?

A. The NPAC is a National Provider Advisory Council. And it's a UBH group that is comprised of external providers.

Q. Back to the BSAC for a moment, what organizations are

represented on the BPAC?

A. Several organizations, including the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, National Association of Psychiatric Health Systems, ASAM, and several others.

Q. Now, directing your attention to Exhibit 11 -- actually, one more question.

As network providers, is it your understanding that these external clinicians are clinicians who would have experience with coverage decisions being made pursuant to UBH's Level of Care Guidelines?

A. Yes.

Q. Okay. Now directing your attention to Exhibit 1189.

A. Yes.

Q. You recognize this document?

A. Yes.

Q. What is it?

A. It is a email from Johnna Sears. And it represents -- or it's an invitation regarding the BSAC, and includes the BSAC agenda for a meeting that occurred in March of 2016.

Q. And you're a recipient to this email; is that right?

A. Yes.

MR. RUTHERFORD: We'd move to admit Exhibit 1189, Your Honor.

MR. KRAVITZ: No objection.

THE COURT: Admitted.

(Trial Exhibit 1189 received in evidence.)

BY MR. RUTHERFORD:

Q. Dr. Triana, this is a BSAC agenda from March 2016; is that right?

A. Yes.

Q. Do you recall whether this is a meeting that you attended?

A. I believe I attended this, yes.

Q. Okay. Directing your attention to Trial Exhibit 1189-0007.

Do you have that in front of you?

A. Yes, I do.

Q. What do we see on Trial Exhibit 1189-0007?

A. So this is a copy of the -- of a roster of the committee members, of the BSAC committee members. And it divides it into the external members and the internal members, and includes their title, and then whether they were present or absent at that meeting.

Q. And then under the column that says "Title."

A. Yes.

Q. Do you see those organizations?

A. Yes.

Q. And are those some of the organizations that you just mentioned a few moments ago?

A. Yes.

Q. Now, turning to 1189-0008, if you could.

Could you explain, just briefly, how these minutes displayed on 008 are laid out, what are each of the columns?

A. Yes.

So on the left side, left column, it has the topic that was going to be discussed during that meeting. The middle column, that's titled "Summary of Discussion," gives a brief summary of that discussion. And then the next column over has "Next Steps," if there were any next steps associated with that particular topic. And if there were, the last column shows who was going to be the responsible party for following up on those next steps.

Q. If I could direct your attention down to the first entry, under "Annual Review of our Guidelines." Do you see that?

A. Yes.

Q. And the first entry states:

> "G. Niewenhous, currently we are beginning our annual solicitation of input regarding our clinical psych and neuropsych testing guidelines. Per the usual process, we want to reach out to our members of BSAC to see if anyone would like to suggest representatives to provide input on these guidelines. This year, we are particularly interested in those related to nontraditional wrap around services, such as Psych Rehab, since we've been implementing Medicaid contracts for those types of

services."

Do you see that?

A. Yes.

Q. What does that explain? First of all, who is G. Niewenhous?

A. That's Jerry Niewenhous.

Q. What does this indicate is taking place?

A. So it indicates that he's in the process of beginning the whole process of reviewing the guidelines on an annual basis.

And this is his reminder to the BSAC members that, A, we would like their input; but, also, B, if they had anybody in particular they wanted to also recommend, for us to obtain input from, to let us know so that we would reach out to them as well.

Q. Was it important to you that the BSAC members were reviewing and commenting on the UBH guidelines?

A. Yes.

Q. Why is that?

A. Because many of them, obviously they represent providers. They -- which, you know, are out in the community treating our members and using our guidelines. They also -- the organizations -- many other organizations have practice guidelines as well. So it was important to receive that feedback, as well, for us.

Q. So the next stage in the process, once the solicitation

has gone out and feedback has received, what happens -- what happens next in the process?

A. So we would get together, the Level of Care Guideline Workgroup, and we would have a meeting and discuss all the different items, which would include the guideline revision or draft guideline, the input from the various individuals. And we would have that -- that meeting.

Q. Prior to having the meeting of this group -- which I'll ask you about in a second -- did Jerry and his team do anything to pull together the feedback that was received?

A. Yes. They would develop a grid. So they would reach out to the individuals. They would get that feedback. And then they would develop a grid that would outline that feedback for that year.

Q. This group that you just mentioned, did it have -- it gets together to talk about the Level of Care Guidelines, does that group have a name? Or did it have a name?

A. Yes, it was the Level of Care Guideline Workgroup.

Q. Is there still a Level of Care Guideline Workgroup, to your knowledge?

A. Yes.

Q. Were you a member of the Level of Care Guideline Workgroup?

A. Yes.

Q. Between 2011 and 2017, who were some of the other members

of the Level of Care Guideline Workgroup?

A. So our chief medical officers. So, for example, Dr. Robinson-Beale, Dr. Bonfield, Dr. Bruce Bobbitt, myself, Jerry Niewenhous, Dr. Pete Brock, Dr. Martorana. Those are some of the folks that would be part of that.

Q. Turning your attention to what has previously been admitted as Exhibit 516.

A. Yes.

Q. Do you recall seeing this exhibit when you testified last week?

A. Yes.

Q. You testified a moment ago, I think, that to get the Level of Care Guideline Workgroup meeting started, a calendar invitation would go out?

A. Correct.

Q. Typically, who would send that calendar invitation?

A. Usually it would be Loretta Urban.

Q. Is this -- at Exhibit 516, is this an example of the type of calendar invitation that you would receive?

A. Yes.

Q. And was this the process each year for the -- for the Level of Care Guideline Workgroup?

A. Yes.

Q. Now, it looks like Exhibit 516 indicates some attachments to it. Do you see that?

A. Yes.

Q. Typically, what was attached to the calendar invitations for the Level of Care Guideline Workgroup meeting?

A. So you would have a copy of what we would call a draft or red-line version of the upcoming guidelines. You would also have a summary sheet indicating some of the changes from the last -- the previous guideline to this guideline. And then there would also be an attachment having the feedback from all the individuals that -- that sent that feedback in regarding the guidelines.

Q. What was your practice with respect to what you did with this information in preparation for the Level of Care Guideline Workgroup meeting?

A. So I would open these documents and become familiar with them and take a look at them. And that's what I would do.

Q. Okay. After receiving this calendar invitation -- I guess, is a calendar invitation typically setting up a conference call? a WebEx? an in-person meeting? What would the Level of Care Guideline Workgroup meeting be?

A. It would be, typically, a telephonic conversation via a WebEx as well.

Q. Again, turning to the top it, says "2016 Guideline Feedback Revised." Do you see that?

A. Yes.

Q. Would the feedback chart delivered to the Level of Care

Guideline Workgroup typically be reviewed during the level of care guideline meeting?

A. Yes.

Q. And what did the Level of Care Guideline Workgroup generally talk about with respect to the feedback that was received?

A. Depended on the feedback. You know, some feedback there really wasn't anything much to discuss. Some feedback there would be a larger discussion. But, typically, we would just go through the grid. And then as we would get through it, we would make comments. We'd, you know, have discussion depending on what the topic was.

Q. Now, was the feedback, was the feedback ever received -- was the feedback received ever critical of the Level of Care Guidelines?

A. Yes, sometimes.

Q. And, typically, what -- how would the Level of Care Guideline Workgroup approach critical feedback?

A. We would review it and see what the recommendation was or what the feedback was.

Q. Now, you testified last week about a few of the feedback charts. Do you recall that?

A. Yes.

Q. Okay. Directing your attention to Exhibit 1252.

A. Yes.

Q. Do you recognize this document?

A. I do.

Q. What is it?

A. This is a copy of the feedback that we had received for the 2011 guidelines.

MR. RUTHERFORD: Your Honor, we would move to admit Exhibit 1252 into evidence.

MR. KRAVITZ: No objection.

THE COURT: Admitted.

(Trial Exhibit 1252 received in evidence.)

BY MR. RUTHERFORD:

Q. Now, before your testimony today, did you have an opportunity to review the feedback on this chart at 1252?

A. Yes.

Q. And did that feedback -- and this feedback is commenting on what year of the Level of Care Guidelines?

A. 2011.

Q. And did this feedback include any commentary stating that the words "clear and compelling," in the continued service criteria, were inconsistent with generally accepted standards of care?

A. No.

Q. Or that the words "clear and compelling" should be deleted from the 2011 Level of Care Guidelines?

A. No.

Q. Now, directing your attention to Exhibit 1253.

MR. KRAVITZ: I'm sorry, I didn't hear the number.

MR. RUTHERFORD: I'm sorry, 1253.

MR. KRAVITZ: That is my fault.

BY MR. RUTHERFORD:

Q. Do you recognize this exhibit?

A. Yes.

Q. What is it?

A. This is a copy of the feedback that we had received for the 2012 guidelines.

MR. RUTHERFORD: We'd move to admit Exhibit 1253 into evidence.

MR. KRAVITZ: There's no objection.

THE COURT: Admitted.

(Trial Exhibit 1253 received in evidence.)

BY MR. RUTHERFORD:

Q. Dr. Triana, directing your attention to page 1253-0009. Are you there?

A. No, not yet.

Yes.

Q. What do we see on page 0009?

A. This is just a sample of the type of information that we would get on the feedback. And it basically has the section where the feedback is -- the comments are related to the actual feedback, if there was any action, and then the source of the

feedback.

Q. And under "Source" it has "PIC" and "USB-HPC." What -- what do those stand for?

A. PIC is the Parity Implementation Coalition, which was comprised of external providers. And then the USB-HPC was representatives of the network in California.

Q. And are those UBH employees?

A. No.

Q. And do you see the sixth --

MR. RUTHERFORD: One moment, Your Honor.

BY MR. RUTHERFORD:

Q. In other words, do you understand that UBH, in 2012, was receiving feedback on its Level of Care Guidelines from external sources?

A. Correct.

Q. Now, directing your attention to Exhibit 1254.

A. Yes.

Q. I'm sorry, if you could go back to Exhibit -- I'm sorry, back to Exhibit 1253, at page 0009, one more time.

A. Yes.

Q. Did the feedback that was received -- well, let me ask it this way:

Did UBH receive positive feedback, critical feedback, and feedback in the middle, for each of the years that it was soliciting feedback?

A. It did.

Q. Okay. And so would -- if you look at the sixth -- okay.

Now I'm going to direct your attention to Exhibit 1254. I'm sorry. Let me know when you have that in front of you.

A. Yes.

Q. Do you recognize this document?

A. Yes. This is the feedback for the 2013 guidelines.

MR. RUTHERFORD: Your Honor, we move to admit Exhibit 1254 into evidence.

MR. KRAVITZ: No objection.

THE COURT: Admitted.

(Trial Exhibit 1254 received in evidence.)

BY MR. RUTHERFORD:

Q. And in the right-hand column, Dr. Triana, do you see, under "Source" it says "Provider" --

A. Yes.

Q. -- on page 0002?

And then further down, on page 0003, it indicates "Staff."

A. Yes.

Q. Where it says "Provider," is that feedback that is coming from an external source?

A. Correct.

Q. And where it says "Staff," is that feedback that's coming from an internal source?

A. Yes.

Q. Now, directing your attention to Exhibit 1260.

A. Yes.

Q. Do you recognize this document?

A. Yes. It's the feedback for the 2015 guidelines.

Q. Okay. Now, directing your attention to page 0002.

A. Okay.

Q. Does this page contain feedback that you would characterize as positive?

A. No.

Q. Does it contain feedback that you would characterize as critical?

A. Yes.

Q. Specifically from whom?

A. Dr. Axelson.

Q. Who is Dr. Axelson?

A. Dr. Axelson is a physician. And he's associated with the American Academy of Child and Adolescent Psychiatry, and one of the members of our BSAC.

Q. And specifically directing your attention to the second piece of feedback, where it states:

> "Thank you for the opportunity to review and comment on the UM UMLOC guidelines. I took the opportunity to share them with the AACAP committee that has developed and tested the AACAP CASII, Child and Adolescent Services Intensity Instrument."

Then it goes on to talk about the CASII. Do you see that?

A. Yes.

Q. What is the CASII? Are you familiar with that?

A. Yes. It's a scoring instrument that the AACAP developed. And it can be used in the placement of children and adolescents.

Q. Was Dr. Axelson a regular commenter on the UBH clinical guidelines?

A. Yes.

Q. And was he somebody who regularly advocated the use of the CASII?

A. Yes.

Q. And is his organization an organization associated with the CASII?

A. Yes. They're the ones that actually develop it.

Q. Now, do you recall the testimony last week, involving a Dr. Bernstein, generally some feedback that UBH received from a Dr. Bernstein --

A. Yes.

Q. -- where he was critical of the "why now" inclusion in the guidelines?

A. Yes.

Q. Directing your attention to the second to last comment on Trial Exhibit 1260, at 0002, do you see that?

A. Yes.

Q. And is that comment from Dr. Bernstein?

A. Yes.

Q. And what does that comment read it?

A. Says:

"I reviewed the guidelines that are most relevant to my outpatient psychological practice. For the most part, they are clear, exhaustive, and seem to offer adequate support for making decisions."

Q. Now directing your attention to 003, just below.

A. Yes.

Q. The second row from the bottom, do you see there's a discussion of custodial care?

A. Yes.

Q. And it indicates that it's a feedback coming from Carla Phillips.

Do you know who Carla Phillips is?

A. Yes.

Q. Who is Carla Phillips?

A. She is one of our internal clinicians.

Q. And she -- her feedback is that:

"The language defining custodial care would be greatly enhanced if it included the language that ongoing care is not solely for the purpose of protective detention."

Do you see that?

A. Yes.

Q. And then she goes on to describe why that caveat best describes a situation, that she says:

> "We often find when adolescents are being maintained at a residential level of care for custodial care. And it is easier for members and providers to understand the more traditional medical definitions of custodial care as they apply to adolescents."

Do you see that?

A. Yes.

Q. Now, under the third column from the right, it indicates "No action." Do you see that?

A. Yes.

Q. And then states "Cannot change a definition of custodial care."

A. Correct.

Q. Do you know why the definition of custodial care could not be changed in the Level of Care Guidelines?

A. Because the source for that was the plan language in the COCs, the certificates of coverage.

Q. Back to the Level of Care Guideline Workgroup meetings. What would actually take place? Was there, like, a group discussion leader in the Level of Care Guideline Workgroup meetings?

A. No. Typically, Jerry would get us through the agenda.

And, basically, we would just get through the document, and all of us would offer our opinions. And at the end of that meeting, the idea was that we would have agreed upon developing what the next draft of the guidelines would be.

Q. After the Level of Care Guideline Workgroup reviewed the documents and the feedback and discussed the changes, what happened next?

A. Then all those changes, everything would be incorporated into a final draft version, which would then be presented to the appropriate committee, the BPAC.

Q. Okay. And -- well, for which years would it be submitted to the BPAC?

A. For every year but this 2017 year.

Q. And in 2017, which committee received the work product from the Level of Care Guideline Workgroup?

A. The Utilization Management Committee.

Q. Okay. Now, in your testimony last week, you testified that you were, from 2011 to 2016, the co-chair of the BPAC?

A. Yes.

Q. Just explain, briefly, why was the BPAC created initially, and what was its general purpose?

A. So the BPAC was created in 2010, as a result of the Amendment Parity Act. And its charge was to develop a standardized approach to the guideline development process, especially the Coverage Determination Guidelines, the CDGs.

And then it was in charge of making sure those were distributed and applied appropriately across the organization.

Q. Now, while the -- okay. So initially it was for the Coverage Determination Guidelines, but then also took over responsibility of updating the Level of Care Guidelines?

A. Right. I think around 2012, it also took the responsibility of reviewing and updating and approving the Level of Care Guidelines on an annual basis.

Q. Once -- from 2011 to 2017, once the BPAC approved a change to the Level of Care Guidelines, did any other committees or individuals within UBH need to further approve that change?

A. No.

Q. So what happened once there was a change approved for the guidelines during this annual process by the BPAC?

A. Once the -- once the guideline would be approved, then from there it would be posted in the various places; you know, for external providers. I think Provider Express.

And then once that would get done, we would also notify the internal staff of the fact that the updated guidelines had been posted.

Q. So what is Provider Express?

A. Provider Express is a web portal that all providers can access, and includes or houses our guidelines.

Q. These BPAC meetings, were these meetings held in person or over the phone or by WebEx, or some combination?

A. They were telephonically, with typically a WebEx component as well.

Q. And maybe I asked this, but were the Level of Care Guideline Workgroup meetings also done by WebEx?

A. Yes.

Q. And does that mean that certain documents can be displayed while everyone is talking on the phone?

A. Yes.

Q. Okay. Now, with respect to the typical BPAC meeting, typically, you know, during that 7-year period of time, how long do these meetings last or would these meetings last?

A. They would go anywhere from 30, 45 minutes, to an hour and a half, is what we would block out.

Q. You may have testified about this last week, but how often during the year are they held, the BPAC meetings?

A. They were held usually twice a month or every other week.

Q. So the Level of Care Guideline Workgroup met how many times a year?

A. They would meet anywhere from, oh, 26 to 30 times a year.

Q. No. The level of care guideline group.

A. Sorry. The Level of Care Guideline Workgroup would meet once a year. At least once a year.

Q. But the BPAC would meet more often?

A. More often, yes. Sorry.

Q. Did the BPAC have a practice of keeping minutes of its

meetings?

A. Yes.

Q. Directing your attention to Exhibit 332.

A. Yes.

Q. Do you recognize this document?

A. I do.

Q. What is it?

A. It is a copy of the BPAC minutes from March 20 of 2012.

MR. RUTHERFORD: Okay. We'd move to admit Exhibit 332 into evidence.

MR. KRAVITZ: No objection.

THE COURT: Admitted.

(Trial Exhibit 332 received in evidence.)

BY MR. RUTHERFORD:

Q. Okay. And just very briefly, how are the minutes laid out to convey what information?

A. So similar to the private set of minutes, it has a topic on the left column, where we would discuss whatever that topic was. The summary of that discussion would be in the middle column, labeled "Discussion." Conclusions would be the next column. And that would be whether there's any action item or if something was approved. And then follow-up column is whether there was any action items that needed to be followed up on.

Q. Okay. So then directing your attention to where it says

"New committee structure." Do you see that on the left-hand side?

A. Yes.

Q. Exhibit 332, at 0002?

A. Yes.

Q. That first bullet point, it says:

"As an introduction to the new committee structure, BPAC reviewed the updated charter to reflect new responsibilities and relationships between new and existing committees."

A. Correct.

Q. (Reading)

"BPAC will not only oversee the development and update of the CDGs, but also the Level of Care and Best Practice Guidelines."

Do you see that?

A. Yes.

Q. And then it says:

"Committees/workgroups that will report to BPAC now include the CTAC, CDC, LOCG and CPG."

Do you see that?

A. Yes.

Q. Where it says "LOCG," is that the Level of Care Guideline Workgroup?

A. Correct.

Q. And to the best of your recollection, is this the BPAC meeting at which it was approved that the BPAC would begin approving the Level of Care Guidelines?

A. Yes.

Q. Which is in 2012?

A. Yes.

Q. Directing your attention to, again, a little lower down on the page, at 00002, it's got a notation in the left-hand column that says "Fail-First and Level of Care Guidelines. Jerry Niewenhous."

Do you see that?

A. Yes.

Q. And with Jerry Niewenhous's name there, what significance does it have that Jerry Niewenhous's name is with that topic? What did that mean?

A. So Jerry -- again, he and his team were the ones that were at the front line in helping us develop and draft our guidelines, and would be also in the front line of receiving the feedback from external providers regarding our guidelines. And, also, that team would be the one conducting the research related to any updates from the guidelines as well.

Q. Okay. Now, directing your attention to Exhibit 368.

A. Yes.

Q. Do you recognize this document?

A. Yes.

Q. What is it?

A. It is a copy of the BPAC minutes from March 19 of 2013.

MR. RUTHERFORD: We'd move Exhibit 368 into evidence.

MR. KRAVITZ: No objection.

THE COURT: Admitted.

(Trial Exhibit 368 received in evidence.)

BY MR. RUTHERFORD:

Q. Directing your attention within this exhibit, to page 0005 -- actually, it's going to be 0004. Do you see that?

A. Yes.

Q. Lists the same types of -- of topics but with different language in terms of the columns; is that right?

A. Correct.

Q. And then do you see down, in the middle of page 0005, indicates 2013 Level of Care Guidelines?

A. Yes.

Q. And it says "Presented the 2013 Level of Care Guidelines." Do you see that?

A. Yes.

Q. And then what action was taken by the BPAC with respect to the 2013 Level of Care Guidelines?

A. The BPAC had made some suggestions related to the introduction. And then we reviewed it and approved the 2013 Level of Care Guidelines.

Q. So these are the minutes that indicate that that action

was taking place by the BPAC with respect to the 2013 Level of Care Guidelines?

A. Correct.

Q. Directing your attention to Exhibit 423.

A. Yes.

Q. Do you recognize this document?

A. Yes.

Q. What is it?

A. It's a copy of the BPAC minutes from January 21st of 2014.

MR. RUTHERFORD: We'd move Exhibit 423 into evidence.

MR. KRAVITZ: No objection.

THE COURT: Admitted.

(Trial Exhibit 423 received in evidence.)

BY MR. RUTHERFORD:

Q. On this document, directing your attention to page 0004.

A. Yes.

Q. And to the last column, what happened during this meeting with respect to the 2014 Level of Care Guidelines?

A. So, again, they were presented. And the committee made a recommendation regarding the definition of "medical necessity," and then the guidelines were reviewed and approved.

Q. Directing your attention to Exhibit 434.

A. Yes.

Q. Do you recognize this document?

A. Yes.

Q. What is it?

A. It is a copy of the BPAC minutes from February 18 of 2014.

MR. RUTHERFORD: We'd move to admit Exhibit 434 into evidence.

MR. KRAVITZ: No objection.

THE COURT: Admitted.

(Trial Exhibit 434 received in evidence.)

MR. RUTHERFORD: Did you say "admitted," Your Honor?

THE COURT: Yes, I did.

BY MR. RUTHERFORD:

Q. Okay. Now, first, directing your attention to page 434-00003. Do you see where it says "medical necessity" language there?

A. Yes.

Q. Sort of third row.

What happened at this meeting with respect to "medical necessity" language?

A. So there was a recommended -- from the previous meeting, there had been recommendation that the BPAC take a look at a definition for "medical necessity." That definition was then presented at this particular meeting, and then reviewed and voted on and approved.

Q. And where it says, in that middle column, "COC," do you see that?

A. Yes.

Q. Including a definition from the COC. What is the COC?

A. The Certificate of Coverage.

Q. Now, directing your attention to page 0002, at the top of that page.

A. Yes.

Q. Under "Optional attendee guest name," do you see those two names?

A. Yes.

Q. Okay. Says "Sue Burgeson"?

A. Yes.

Q. Who is Sue Burgeson?

A. Sue was our vice president of consumer affairs.

Q. And what was Sue Burgeson's background?

A. Sue had a very diverse background. She owned a company, and participated and was very active in patient advocacy type of activities. She, herself, was a consumer. So she provided a very unique viewpoint to our members.

Q. By "consumer," what do you mean?

A. By "consumer" means she was a patient herself.

Q. With some sort of behavioral health disorder?

A. Correct.

Q. And what was she meant to represent -- like, who did she represent at the company? What was her role --

A. She would represent the consumers, the members themselves.

Q. And do you know who decided to hire Sue Burgeson?

A. I believe it was Dr. Bonfield, Bill Bonfield.

Q. Is she somebody who was given an opportunity each year to provide commentary and feedback on the Level of Care Guidelines?

A. Yes.

Q. And the Coverage Determination Guidelines?

A. Yes.

Q. Now, directing your attention to Exhibit 482.

Do you recognize this document?

A. Yes.

Q. What is it?

A. It's BPAC minutes from January 20 of 2015.

Q. Okay. And then to page 0004.

Let me know when you're there.

A. Yes.

Q. Do you see where it says "2015 Level of Care Guideline Updates"?

A. I do.

Q. What happened at this meeting with respect to the 2015 Level of Care Guidelines?

A. So, again, we reviewed the guidelines, and then the committee voted on them and approved them.

Q. Okay. Now, go up to "Opening remarks," where it says, "BPAC welcomed two new members to the committee." Do you see that?

A. Yes.

Q. Do you see the two names underneath that statement that I just read?

A. I do.

Q. Okay. Is this the meeting -- see where it says "Fred Motz"?

A. Yes.

Q. "Vice president of Actuarial Services"?

A. Correct.

Q. Was this the first meeting that Fred Motz was attending as a member of the BPAC?

A. Yes.

Q. And was Mr. Motz on the BPAC before this meeting?

A. No.

Q. Was any representative from finance on the BPAC before this meeting?

A. No.

Q. And prior to this meeting, had Mr. Motz, to your knowledge, ever attended a meeting where the BPAC discussed and approved Level of Care Guidelines?

A. Not that I remember.

Q. Directing your attention to Exhibit 519.

A. I'm sorry, to which one?

Q. 519.

A. Yes.

Q. Do you recognize this document?

A. I do.

Q. What is it?

A. It is a copy of the BPAC minutes from January 19 of 2016.

MR. RUTHERFORD: Before I ask that question, Your Honor, may I move Exhibit 482 into evidence?

MR. KRAVITZ: No objection.

THE COURT: Admitted.

(Trial Exhibit 482 received in evidence.)

BY MR. RUTHERFORD:

Q. Okay. Back to Exhibit 519, Dr. Triana. You said you recognize this. What is it?

A. This is a copy of the BPAC minutes from January 19 of 2016.

Q. Okay. And then directing your attention to page 0004. What, if anything, occurred at this meeting relative to the Level of Care Guidelines?

A. So, again, the guidelines were reviewed and then voted on and approved by the BPAC for the 2016 guidelines.

Q. Now, back to page 519, at 0002. Do you see that?

A. Yes.

Q. Do you see where it says -- it's got the committee member names?

A. Yes.

Q. And titles?

A. Yes.

Q. And whether they attended or not?

A. Correct.

Q. And this was a meeting that Mr. Motz did not attend; is that right?

A. That's correct. He was not at that meeting.

Q. Directing your attention to Exhibit 1143.

A. Yes.

Q. Do you recognize this document?

A. I do.

Q. What is it?

A. It's a copy of the BPAC minutes from April 2nd of 2013.

Q. And then within --

MR. RUTHERFORD: We'd move to admit this document into evidence, Your Honor, Exhibit 1143.

THE COURT: Admitted.

MR. KRAVITZ: No objection.

(Trial Exhibit 1143 received in evidence.)

BY MR. RUTHERFORD:

Q. Directing your attention, Dr. Triana, to page 0003.

A. Yes.

Q. To the last entry on -- on that page, where it says "BSAC request to post guideline changes."

A. Yes.

Q. It indicates that:

"Continued discussion about BSAC's request to post guideline changes and a red-line version of the guidelines recommended that BSAC be notified of changes made based on their input that the National Provider Advisory Council be similarly notified. And that A committee accepted the recommendation to notify BSAC of changes made based on their input to similarly notify the National Provider Advisory Council and to post a summary of significant changes on Provider Express."

Do you see those two statements?

A. Yes.

Q. What is that conveying?

A. The BSAC representatives had requested that if, as a result of some of the recommendations they had made, any changes were made, that those changes would get informed back to the BSAC membership. And then, also, the suggestion was that it would also occur to the NPAC membership as well.

Q. Generally, what was the level of engagement at the BPAC meetings?

A. It was good.

Q. What was your role during those meetings as the co-chair? What did the co-chair do during a typical BPAC meeting?

A. So, typically, I was in charge of making sure, first of all, that we would get through the agenda. I would make sure that there was adequate discussion of the various topics. I

would make sure that if there was any topics that required a vote, that we would follow the appropriate procedures regarding that. And I would make sure that the committee members were engaged.

Q. Do you know what an SME is?

A. Yes.

Q. What is it?

A. It's a subject matter expert.

Q. And were subject matter experts ever invited to attend BPAC meetings?

A. Yes.

Q. Whose responsibility was it to invite those subject matter experts?

A. Either me or Jerry Niewenhous.

Q. Now, you testified last week that after the BPAC, I think, was sunsetted or disbanded in 2016, the Utilization Management Committee took over responsibility for approving the guidelines; is that right?

A. Yes.

Q. And were you -- what was your role in the UMC?

A. I was also a co-chair for the UMC.

Q. Are you currently on the UMC?

A. No.

Q. And was the process that you described for updating the Level of Care Guidelines, even after the UMC, the same from

2011 to 2017?

A. Yes.

Q. Now, were you also involved in the annual updates to the Coverage Determination Guidelines?

A. Yes.

Q. What was your involvement there?

A. The CDG revisions and updates would be presented to the BPAC. So I would review them in that capacity.

Q. Are you familiar with a committee called the Coverage Determination Committee?

A. Yes.

Q. Were you a member of the Coverage Determination Committee?

A. No.

Q. Do you know what the role of the Coverage Determination Committee is or was?

A. Yes.

Q. What is that?

A. It was to create the CDGs, the Coverage Determination Guidelines, and update those, and then develop a draft of the CDGs.

Q. Was the Coverage Determination Committee similar in its function to the Level of Care Guideline Workgroup?

A. Yes.

Q. Now, between 2011 to 2017, were the Level of Care Guidelines fully incorporated into the Coverage Determination

Guidelines -- wait. I'm sorry. Were the -- let me ask this a little bit differently.

You were asked last week a question as to whether or not the Level of Care Guidelines were fully incorporated into the Coverage Determination Guidelines.

Do you recall that?

A. Yes.

Q. I think I asked you that question.

Now, for some Coverage Determination Guidelines, are the words of the Level of Care Guidelines literally, like, copied and pasted into the Coverage Determination Guidelines?

A. Yes.

Q. Is that true for every CDG, though, between 2011 and 2017?

A. No.

Q. If the words of the Level of Care Guidelines were not copied and pasted into the CDG, would a peer reviewer have been allowed to open up the Level of Care Guidelines and apply them in a CDG benefit determination?

A. No.

Q. Is that true even if the CDG made a reference to the level of care guideline as opposed to fully incorporated it?

A. Yes, that's true.

Q. Now, Dr. Triana, do you have an understanding about whether the Level of Care Guidelines from 2011 to 2017 were consistent with generally accepted standards of care?

A. Yes.
Q. What is that understanding?
A. That they were.
Q. And what is that -- what is that understanding based on?
A. It's based on the fact that our guidelines are evidence-based. We use scientific evidence. Our guidelines use and reference other guidelines, like practice guidelines, external guidelines and such. The fact that they were viewed by individuals actively practicing psychiatry and treating our members. It's also based on my own clinical experience in treating patients as well.
Q. And what role, if any, did this external feedback that you received play in your determination that the Level of Care Guidelines and Coverage Determination Guidelines were consistent with generally accepted standards of care?
A. The feedback was very important to me. And the feedback, in general, was positive regarding that.

So I used that as a point of validation of the generally accepted -- that our guidelines are consistent with generally accepted standards of medical practice.

MR. RUTHERFORD: No further questions, Your Honor.

THE COURT: Okay. Cross.

(Pause)

MR. KRAVITZ: Too many notebooks.

THE COURT: Mr. Kravitz, will you be using any of the

exhibits that were jointly agreed upon to be sealed?

MR. KRAVITZ: Well, you know, I was planning to use some of them. But I'm not sure, given what he just testified to, that I'm going to get to them. I've got the list here so that -- I don't -- actually, looking at this, I don't think so. But --

THE COURT: Okay.

MR. KRAVITZ: Do you want me to take two minutes and figure it out?

THE COURT: No, I don't. I want you to not use them. Or if you're going to use them, use them at the close of your examination and announce it before you do it.

MR. KRAVITZ: Absolutely.

THE COURT: Okay.

MR. KRAVITZ: I wasn't -- I wouldn't have considered using them without making --

THE COURT: No, I just want to make sure you don't use them in the middle and we send people in and out.

MR. KRAVITZ: Got it. Okay. Makes perfect sense.

CROSS-EXAMINATION

BY MR. KRAVITZ:

Q. Dr. Triana, good afternoon.

A. Good afternoon.

Q. You just testified that one of the reasons that UBH creates its own guidelines is with respect to its clinical

vision. Do you remember that?

A. Correct.

Q. And I think you mentioned "recovery and resiliency." You recall that?

A. Correct.

Q. And you recall the last time that you testified that you also talked about "why now" as being part of the clinical vision?

A. Correct.

Q. Let's talk about the BPAC, if we may.

And the first thing is, you know and knew, while you were the chair, that the guidelines were supposed to be consistent with generally accepted standards of care?

A. Yes.

Q. And I assume that you, as the chair of the BPAC, must have made sure that the members of the committee knew that the guidelines were supposed to be consistent with generally accepted standards of care?

A. Yes.

Q. And that they were supposed to be evidence-based?

A. Yes.

Q. And not be adopted, rejected, or revised for a business reason. Is that true as well?

A. Yes.

Q. And in terms of the materials that went to the BPAC, I

believe that you mentioned today that what it was that the level of care -- level of care guideline workgroup would get. Do you recall discussing that?

A. Yes.

Q. And I think that you said that that group would get -- what I heard to you say was, like, a red-line of the guidelines so that the workgroup could see what the proposed changes were?

A. Correct.

Q. And, also, I think that you said that the workgroup would get those grids of the feedback; is that correct?

A. Yes.

Q. So those were the two principal documents that the workgroup got?

A. Correct.

Q. Now, in terms of what the BPAC got, as I understand it, the BPAC would get the red line or its equivalent; right?

A. Yes.

Q. But the grids of the feedback did not actually go to the BPAC; correct?

A. Correct.

Q. And then, in terms of the evidence base, let's -- let's talk a little bit about that. My understanding, from your prior testimony -- or let me -- scratch that. Let me start again.

My understanding is that if there was a proposed change,

you more than likely would look at the supporting evidence. Is that true?

A. A proposed change to the guideline?

Q. Yes.

A. It depended on it, yes.

Q. Okay. So sometimes you might look at the supporting evidence, and other times you might not. Is that fair?

A. That's fair.

Q. And whatever material you did look at would be supplied by Mr. Niewenhous and his team; is that correct?

A. Correct.

Q. And then, I think, beginning in 2016, Mr. Niewenhous was replaced by Mr. Rockswold?

A. Correct.

Q. Is that right?

A. Correct.

Q. But absent a proposed change, you as the chairman of the BPAC and a member of the workgroup would not go back and revalidate the evidence base for the guidelines. Is that true?

A. We would always review the guideline, whatever the new version of it. And we would review it in its entirety.

Q. Right. And, I'm sorry, I think my question was not entirely clear. I wasn't talking about guideline.

A. Okay.

Q. I understand that you looked at the guideline and the

changes and red-line; right?

A. Yes.

Q. I'm talking about the evidence base that supports the guidelines, okay.

A. Yes.

Q. And in terms of that, if there wasn't a change to a particular part of the guidelines, you didn't go back and take a look at what the evidence base was; is that correct?

A. Typically not.

Q. Right. And that was the job of Mr. Niewenhous; is that correct?

A. To monitor the annual changes or any updates to the practice guidelines, yes.

Q. And it was also his job to monitor the validity of the evidence base?

A. Yes.

Q. Okay. But if anybody had that responsibility, it would have been Mr. Niewenhous; correct?

A. Yes. At the same time, all of us are licensed and were clinicians; right. And I'm a member of the American Psychiatric Association. So we would individually get updates to practice guidelines, and those sort of things, just as a course of our, you know, licensure, CME activities as well.

Q. Okay.

Q. But just to be clear, in terms of the job of monitoring the evidence base, that was Mr. Niewenhous's job; correct?

A. Yes.

Q. And then Mr. Rockswold's; right?

A. Correct.

Q. And Mr. Niewenhous was not a medical doctor; is that correct?

A. That's correct.

Q. And as I understand it, he's an unlicensed social worker?

A. Correct.

Q. And Mr. Rockswold also isn't a medical doctor?

A. Correct.

Q. And my understanding is he is not a licensed or professional clinician; is that correct?

A. I'm not sure what his credentials exactly are.

Q. In terms of the BPAC and its job of approving or disapproving changes to the guidelines, as I understand it, Mr. Niewenhous would -- or perhaps someone from his group -- would present proposed changes to the BPAC. Is that how it would work?

A. Yes.

Q. And --

THE COURT: Who drafted the proposed changes?

THE WITNESS: So the Level of Care Guideline Work

Group would be the one that would develop the final draft.

The actual typing it?

THE COURT: No. Who came up with the language in the first instance to propose to the Level of Care Guidelines Work Group? Was that Mr. Niewenhous?

THE WITNESS: Yes. Mr. Niewenhous and his team would make their suggestions.

THE COURT: Okay. Thank you.

Who's on his team?

THE WITNESS: Loretta Urban was on his team, and I'm not sure who else was on his team.

BY MR. KRAVITZ:

Q. And, Dr. Triana, the requirement that the guidelines be evidence based was important to UBH; is that correct?

A. Yes.

Q. Now, in terms of the BPAC's role, it's true that you do not recall an example of anyone on the BPAC ever opposing a proposed change to the guidelines; is that right?

A. I'm not sure that I ever said that. There could have been a chance, but I can't recall an example of that.

Q. All right. So you might recall that there were discussions of changes, but you don't recall an example of someone actually opposing a change?

A. Correct.

Q. Let me ask you about -- if I can find it in my morass of

paper here -- Exhibit 1235, which is somewhere in the vicinity.

And as I understand it, Exhibit 1235 was a list of internal and external people from whom feedback was solicited; is that correct?

A. Yes. Yes.

Q. I'll give you a chance to find it too since --

A. Yes.

Q. Okay. But this is not -- "this" being Exhibit 1235 -- is not necessarily a list of people who provided feedback; correct?

A. Correct.

(Pause in proceedings.)

MR. KRAVITZ: Sorry.

Q. If you could turn to Exhibit 114 [sic], please.

A. (Witness examines document.) Which binder is that in? Sorry.

Q. Yeah, good question. I think it's in -- well, it was in the -- it was on the list of documents that UBH identified for you.

(Plaintiffs counsel conferring.)

MR. KRAVITZ: 1114. What did I say?

MS. REYNOLDS: 114.

THE WITNESS: Oh. Yes.

BY MR. KRAVITZ:

Q. I'm sorry. Okay. I'm sorry. I misspoke.

A. (Witness examines document.) Yes.

Q. Okay. And this is a letter from Dr. Bernard Bogard to UBH dated January 20th, 2012, and it's a response to the feedback solicitation letter; is that correct?

A. Yes.

Q. And if you go down to the end of the first paragraph, it says (reading):

"In return for your written comments, we will reimburse you $150."

Do you see that at the end of the first paragraph?

A. Yes.

Q. Okay. And that's what the financial reward was or payment was for providing solicitation -- I mean, for feedback?

A. That was not part of my job, so I cannot confirm that.

Q. And then if you look down, you can look at Dr. Bogard's feedback, and it says (reading):

"Do the guidelines offer adequate support for making decisions about care? Yes.

"Are the guidelines organized in a manner that makes them easy to use? Yes.

"Are the criteria that are" -- "Are there criteria that are ambiguous or unclear? No.

"Are there criteria that should be added or deleted? No."

Did I read that right?

A. Yes.

Q. Let's take a look at another feedback letter. If you look at Exhibit 11 --

MR. KRAVITZ: Oh, I move 1114 into evidence.

MR. RUTHERFORD: No objection, Your Honor.

(Trial Exhibit 1114 received in evidence)

BY MR. KRAVITZ:

Q. And if you would turn to Exhibit 1116 in your book.

A. Yes.

Q. And this is another feedback letter from 2012. Do you see that?

A. Yes.

MR. KRAVITZ: And I move 1116 into evidence.

THE COURT: It's admitted.

MR. KRAVITZ: Oh, go ahead.

MR. RUTHERFORD: No objection.

THE COURT: Okay.

MR. RUTHERFORD: Sorry.

(Trial Exhibit 1116 received in evidence)

BY MR. KRAVITZ:

Q. And just one more (reading):

"Dear Gerard:

"I reviewed the guidelines. I found them to be very clear, easy to follow. I think that they will be very helpful in making decisions about patient care. They have

become much more readable, user friendly over the years."

Did I read that right?

A. Yes.

(Pause in proceedings.)

BY MR. KRAVITZ:

Q. If you would turn to Exhibit 1260, please.

A. (Witness examines document.)

Q. I know. The books are very hard here. 1260, when you get it, I believe is one of the grids --

A. Yes, sir.

Q. -- for the feedback 2015 Level of Care Guidelines?

A. Yes.

Q. And if you look at page 0002, do you see that?

A. Yes.

Q. And at the top of that page I believe you were asked some questions about that excerpt from a comment by Dr. Axelson. Do you see that?

A. Yes.

Q. And you see that he's recommending that UBH adopt the CASII instrument? Do you see that?

A. Yes.

Q. And that is not something that UBH has ever done; is that correct?

A. That's correct.

Q. And UBH has never adopted any special set of rules for

children or adolescents; correct?

A. That is correct.

Q. And do you recall whether or not Dr. Axelson's comment on CASII was ever discussed at the BPAC level?

A. I don't recall it being discussed at the BPAC level.

Q. Do you recall whether it was discussed at the Level of Care Work Group level?

A. Yes.

Q. But the decision was made not to adopt it; correct?

A. Correct.

Q. I did want to ask you about another one of these things here. It's Exhibit 1253. I believe you were asked some questions about that. I believe that was the feedback grid for the year 2012.

A. Yes.

Q. And if you look to page 0009, do you see that, that page? Can you find it?

A. (Witness examines document.) Yes.

Q. And you note that there is a comment about the residential rehab guideline change? Do you see that? It's the top one by PIC. It says --

A. Yes.

Q. -- in the residential rehab guideline change any, I think it should say "any of the following criteria must be met." Change it to "any one of the following criteria must be met."

And then each of these -- and each of these criteria with an "or." Do you see that?

A. Yes, sir.

Q. Okay. And I'd like to take a quick look at that Residential Rehab Level of Care Guideline, which I think is Exhibit 2 at page 28.

A. (Witness examines document.)

Q. Okay. Have you found that in the book?

A. Yes. Page 28.

Q. Yes.

And if you -- so, first of all, that's the residential treatment center mental health conditions; is that correct?

A. Yes.

Q. For 2012; right?

A. That's correct.

Q. And if you flip the page to 0029, you'll see that there is a paragraph 5. Do you see that?

A. Yes.

Q. And then there is a 5b, which starts out, "Treatment in a residential setting," and then it goes on. And then the end of that paragraph says (reading):

"Active treatment is indicated by services that are all of the following..."

Do you see that?

A. Yes.

Q. And there are five bullets or listed factors there; is that correct?

A. Correct.

Q. And you recognize that the first three -- little one, little two, little three -- are consistent with the CMS definition of "active treatment"?

A. Yes.

Q. Okay. But the fourth and fifth bullets are not; correct?

A. They are not consistent with the definition of "active treatment." They're incorporated into the CMS guidelines but not under the active treatment section.

Q. They're not in the "active treatment" definition; is that correct?

A. Correct.

Q. Right. And so if you go back to Exhibit 1253 now, which we were looking at, and there's a comment on this same Level of Care Guideline, do you see that?

A. Yes.

Q. And no one that year commented on the fact that that Residential Rehab Level of Care Guideline actually had a definition that included two additional bullets beyond what was in the CMS definition; correct?

A. Correct.

Q. Right. And as we just saw in Exhibit, I believe, 1114, the solicitation letter at least does not ask the people

reviewing the guidelines to give their opinion on whether or not the guidelines reflect or capture generally accepted standards of care; correct?

A. Correct.

Q. If we could turn, please, to Exhibit 517.

A. (Witness examines document.)

Q. Do you have Exhibit 517 in front of you?

A. Not yet.

Q. Okay.

A. It's in --

Q. Take your time. This is --

A. 517, yes.

Q. Okay. And Exhibit 517 is -- well, let me scratch that.

The top e-mail in Exhibit 517 is from you to Jerry Niewenhous with a copy to Loretta Urban, and it is dated January 12th, 2016, and the subject is "Guideline Input Call Highlights"; is that correct?

A. Correct.

MR. KRAVITZ: I move the admission of Exhibit 517.

MR. RUTHERFORD: No objection, Your Honor.

THE COURT: It's admitted.

(Trial Exhibit 517 received in evidence)

BY MR. KRAVITZ:

Q. And if you would turn to page 0002, please.

A. (Witness examines document.) Yes.

Q. And the e-mail on that page is from Mr. Niewenhous to you with a copy to Ms. Urban; correct?

A. Correct.

Q. And it's the day before on January 11th; right?

A. Correct.

Q. And it says (reading):

"From Friday's call with Bill and Bruce," first bullet, "'Why now' concept. One provider questioned the use of. Bill still favors. Will keep in the guidelines. Prompted a discussion about how well the concept has been operationalized. As follow-up, provided Bill and Bruce with the attached."

Did I read that right?

A. Yes.

Q. Okay. And if you now would turn to page 0001, which is your e-mail of January 12th. Are you with me?

A. Yes.

Q. Okay. And then you say, "Bill likes Magellan's definition." Do you see that at the top?

A. Yeah. That's not me staying that.

Q. Oh, that's not you. Who is that?

A. That's Jerry sending me that e-mail.

Q. Oh, okay. All right. Fine.

So Jerry says, "Bill likes Magellan's definition"; correct?

A. Correct.

Q. And that's referring to the definition of "why now"?

A. (Witness examines document.) Yes.

Q. And Jerry is -- (reading)

"Bill likes Magellan's definition and is concerned that we haven't fully embraced the approach in the day-to-day. He recalled there being a training but couldn't recall whether it was impactful. Bill's interest seemed to be in ensuring that care is being managed in accordance with the guidelines, as well as to see if a more directed solicitation of input might yield more fruit."

Do you see that?

A. Yes.

Q. Did I read that right?

A. Yes.

Q. And then the next paragraph provides (reading):

"As for the level of input from staff and providers, it has trailed off over the years. Nothing in the input explicitly indicates why. That said, prior to the trail-off, we did hear concerns from providers about how the guidelines are applied. Here's two examples from 2010."

Did I read that right?

A. Yes.

Q. And then example one (reading):

"I previously responded to UBH's request for feedback on Level of Care Guidelines on March 6, 2006, and February 12th, 2008. I believe my comments now, which are attached to the proposed guidelines, are similar to my comments then. However, the most disturbing aspect of the guidelines is not so much what is in them," paren, "although in places they are certainly unrealistic and consultive rather than UR but how they are utilized. The reviewers too often do not seem to know or care that clinical experience and judgment can be used in making level of care determinations and that imminent safety is not and should not be the only criteria for a specific level of care. This is especially important for children. Access and availability of treatment is mentioned in your guidelines, but in my experience is only infrequently or rarely used. The inability to utilize less structured treatment and, therefore, requiring a higher level of care should also be considered in the guidelines. Peer reviewers often use these guidelines as a cookbook and do not use clinical judgment."

Did I read that right?

A. Yes.

Q. And then here's the next example (reading):

"Often it appears as if the reviewer's goal is to

deny treatment and use the guidelines to justify the denial. Maybe someday there will be a more collaborative rather than adversarial process between those trying to treat patients and those often preventing treatment. In that way a patient's needs will more likely be met, and I believe in the long run can still be cost effective (for society if not for UBH). Obviously this is my opinion, but determining if this opinion is shared by others and addressing it not only" -- "can not only be helpful for patient care but also may help UBH's reputation and credibility."

Did I read that right?

A. Yes.

Q. I would like now to ask you a bit more -- scratch that.

Let me follow-up. You gave some testimony here today about Mr. Motz and his attendance at the BPAC. Do you recall that?

A. Yes.

Q. And I think that you said before that he would attend once he was on the committee when there was a financial issue; is that correct?

A. He would attend rarely.

Q. Rarely. But if there was a financial issue that was actually being discussed, that is when he would attend; right?

A. I'm not sure when he would attend or not attend. He just

didn't attend very frequently.

Q. Okay. Well, let me move on from that then.

I'd like to talk to you about the testimony you gave that guidelines were supposed to be evidence based and not adopted for business reasons. Do you recall that?

A. Yes.

Q. Okay. If you could turn to 482.

A. (Witness examines document.)

Q. Do you have Exhibit 482 in front of you?

A. I do.

Q. And that is -- strike that.

That document is a set of BPAC minutes from January 20th, 2015; is that correct?

A. Yes.

Q. And you attended that meeting?

A. Yes, sir.

MR. KRAVITZ: Okay. I move the admission of Exhibit 482.

MR. RUTHERFORD: No objection, Your Honor.

THE COURT: It's admitted.

(Trial Exhibit 482 received in evidence)

BY MR. KRAVITZ:

Q. And this was a meeting where Fred Motz did attend; is that correct?

A. Yes.

Q. And Carolyn Regan was there; is that right?

A. Yes.

Q. And Pete Brock from the Affordability Department; right?

A. Yes.

Q. And Mr. Niewenhous was also there; is that correct?

A. Yes.

Q. And then there's someone named Francisca Azocar?

A. Yes.

Q. I assume that's a she?

A. Yes.

Q. And what was her role?

A. I'm not sure exactly what role, but she was in Research -- I believe the Research Department.

Q. Okay. And if you could turn, please, to page 0004 of Exhibit 482.

A. Yes.

Q. And if you look down under the heading of "New Business," do you see that?

A. Yes.

Q. Do you see that "New Business"? And then the third column to the right is (reading):

"BPAC Committee recommended action plan to resolve issue."

Do you see that? That's the third -- that's the heading under the third column reading from left to right.

A. Oh, yes.

Q. Okay. And then look down to the entry under "New Business" in that column.

A. Yes.

Q. Okay. And that entry says (reading):

"BPAC approved the proposed changes to the Level of Care Guidelines. There were two additional areas where BPAC made business decisions impacting the Level of Care Guidelines due to no existing evidence-based practice that could provide guidance. These include:"

Bullet one: "IOP. There is no current best practice documenting that the initial evaluation needs to be completed within three treatment days. BPAC approved keeping this in the guidelines according to the following rationale."

And there are two subbullets.

Well, first of all, have I read that correctly up to that point?

A. Yes.

Q. And then the two subbullets say (reading):

"The initial evaluation is a critical component of treatment planning. Completion of the initial evaluation within three treatment days is reasonable and support safe, efficient, and effective treatment."

Do you see that?

A. Yes.

Q. And then the next bullet, black bullet, down says -- by the way, did I read that right up to that point?

A. Yes. Yes.

Q. And then it says (reading):

"Residential Treatment. There is no current best practice standard that states the initial evaluation needs to be completed within 24 hours of admission. BPAC approved keeping this time frame in the guidelines according to the following rationale:

"The initial evaluation is a critical component of treatment planning. Completion of an initial evaluation within 24 hours is reasonable and supports safe, efficient, and effective treatment."

I read that right?

A. Yes.

Q. Okay. Let's now go to Exhibit 486, please.

A. (Witness examines document.)

Q. And 486 is an e-mail from you to Dr. Martorana and others dated March 9, 2015; is that correct?

A. Yes.

Q. And the subject is "2015 LOCGs Update Training." Do you see that?

A. Yes.

MR. KRAVITZ: I'd like to move into evidence 482,

which is the last document we just discussed, and 486, which is the current one.

MR. RUTHERFORD: No objection. I think 482 may already be in evidence.

THE COURT: Well, they're both admitted.

(Trial Exhibit 486 received in evidence)

MR. KRAVITZ: Okay. All right. Then it doesn't have to come in again. Sorry.

Q. And this is approximately -- "this" being Exhibit 486 -- is approximately, in terms of time, two months after Exhibit 482; is that correct?

A. (Witness examines document.) Yes.

Q. Okay. And your e-mail says (reading):

"Good afternoon. Attached is a highlighted version of the document outlining the changes in the Level of Care Guidelines between 2014 and 2015. (Thanks to Andy Martorana for the highlights!)"

And then if you would turn to page 0004 in Exhibit 486. Actually, I think we have to back up to 0003. And you see that at the bottom of that page there is a black bullet for "Intensive Outpatient Program"?

A. (Witness examines document.) Yes.

Q. Okay. And then under that heading, if you go down, and this is really hard to read, but I think there is a bullet that says "Frequency of visits with a psychiatrist"; is that

correct?

A. Yes.

Q. Okay. And then the next bullet down says "Initial Evaluation." Do you see that?

A. Yes.

Q. And then there are -- under that there are subbullets that say (reading):

"Discussion point for BPAC. No evidence base for the current standard that the initial evaluation be completed within three treatment days of admission. Evidence base doesn't provide an alternative standard. After discussion with Lorenzo Triana and Bill Bonfield recommending that the standard be maintained as a business decision, rationale is:

"The initial evaluation is a critical component of treatment planning, completion of the initial evaluation within three treatment days is reasonable and support safe, efficient, and effective treatment."

Do you see that?

A. Yes.

Q. Okay. And that's what's reported in this substantial change document with respect to the 2015 guidelines?

A. Yes.

Q. And then if you go down, there's a heading that says "Residential Treatment Program." Do you see that?

A. Yes.

Q. That's also on 0004; is that correct?

A. Correct.

Q. And then the first subbullet is "Frequency of visits with a psychiatrist"; is that right?

A. Yes.

Q. And with respect to this one, it says (reading):

"No evidence base for the current standard of twice weekly visits. Replace with guidance from the LOCUS that a psychiatric consultation occurs no less than weekly."

And then under "Initial Evaluation":

"Discussion Points for BPAC. No evidence base for the current standard that the initial evaluation be completed within 24 hours of admission. Evidence base doesn't provide an alternative standard. After discussion with Lorenzo Triana and Bill Bonfield recommending that the standard be maintained as a business decision, rationale is:

"Initial evaluation is a critical component of treatment planning, completion of the initial evaluation within 24 hours is reasonable and supports safe, efficient, and effective treatment."

Did I read that right?

A. Yes.

Q. And in terms of your testimony about Mr. Motz, it is true

that if it was not actually in the BPAC, you did receive information or financial information concerning utilization management and how the company was doing; is that correct?

A. When you say "you," you mean me?

Q. Yes, you.

A. Outside of the BPAC?

Q. Yes.

A. Yes.

Q. Okay. And you would also get UM information from Affordability, correct, outside of the BPAC?

A. Yes, sir.

Q. Now, I do want to ask you a few questions about the BPAC and information that might have been discussed in the BPAC concerning ALOS data.

And just to review the bidding here, I think you testified last week, and it's at transcript pages 704, lines 2 to 9, that the BPAC didn't evaluate UM data, including ALOS data. Do you recall that?

A. Yes.

Q. And then do you also recall that at transcript page -- I'm sure you don't remember the page -- 705, lines 6 to 20, I read you your deposition testimony where you said that if a committee member had a concern about ALOS, that would be the time for the committee member to bring it up? Do you recall that?

A. Yes.

Q. And then I believe that in response to a question by UBH's counsel you said -- and this is at trial transcript 786, line 23, through 787, line 4 -- that you recall no instance of average length of stay data being discussed at the BPAC. Do you recall that?

A. Correct.

Q. Okay. Let's take a look at this, and I would like to ask you about -- if I can find it -- pardon me for one second while I see if I can find my document.

(Pause in proceedings.)

MR. KRAVITZ: Sorry, Judge. I'm just trying to --

THE COURT: It's okay.

MR. KRAVITZ: -- find which of these notebooks it's in. It's not going to be in here.

(Pause in proceedings.)

MR. KRAVITZ: Okay.

Q. I just want to see if you remember this, and it's with respect to a BPAC meeting from July 27 of 2010. You were the chair of the BPAC back then; is that correct?

A. Yes.

Q. And do you recall that Francisca Azocar presented an update on ALOS benchmarks and the pros and cons of using the NIS national benchmarks versus the internally created benchmarks that are being used today? Do you recall that?

A. I have to see the --

Q. Okay. Let me -- and then I'll ask you one more.

Do you recall that there was a discussion about using a hybrid approach to benchmarking? (reading)

"This would include using NIS national and OHBS homegrown data. However, if this method is used, an analysis will have to occur comparing all of the differences and explaining how they will be mitigated."

MR. RUTHERFORD: Objection, Your Honor. If this is for refreshing recollection, there's a process for that. We don't also have a copy of this document.

MR. KRAVITZ: Well, I'm going to give it to you.

THE COURT: Give it to him before you start reading out of it.

MR. KRAVITZ: Well, that's fair enough. I'm sorry.

THE COURT: Thank you.

MR. KRAVITZ: I should have.

Here. I'm sorry. I apologize for that. This is what I -- that's what I just read.

MR. RUTHERFORD: The exhibit number?

MR. KRAVITZ: There isn't one. I'm just going to refresh his recollection.

And may I approach the witness?

THE COURT: Okay.

MR. KRAVITZ: Would you like a copy too?

THE COURT: No. I think I've got the gist.

MR. KRAVITZ: Okay.

Q. I'm handing you these minutes, and I'm just going to show you that I was reading from there (indicating). Okay?

And now that you've said you don't recall, I want to know whether or not this document refreshes your recollection.

A. (Witness examines document.)

Q. Okay.

THE COURT: Let him respond to the question.

MR. KRAVITZ: Okay. Yeah.

THE WITNESS: Yes. Can I read this real quick?

BY MR. KRAVITZ:

Q. Sure. Of course.

A. (Witness examines document.) Yes.

Q. That refreshes your recollection?

A. Uh-huh. Yes.

Q. And do you recall that those discussions occurred?

A. Yes.

MR. KRAVITZ: Okay. I have no further questions.

THE COURT: Okay. Any redirect?

MR. RUTHERFORD: Briefly, Your Honor.

(Pause in proceedings.)

REDIRECT EXAMINATION

BY MR. RUTHERFORD:

Q. Dr. Triana, with respect to that last meeting in 2010,

aside from that meeting seven years ago, do you recall any other meetings since 2010 where ALOS was discussed?

A. I do not.

Q. You indicated there are approximately 25 to 30 meetings per year?

A. Correct.

Q. Directing your attention to Exhibit 1114, this is a solicitation letter that you were asked questions about by Mr. Kravitz; is that right?

A. Yes.

Q. And you were asked specifically about the questions as set forth in that document. Do you see those?

A. Yes.

Q. Was it your expectation that if there was something in the Level of Care Guidelines that was inconsistent with generally accepted standards of care, that these questions would elicit a response from the person from whom feedback was solicited --

A. Yes.

Q. -- to either delete the language or change it?

A. Correct.

Q. And then directing your attention to Exhibits 482 and 486.

A. (Witness examines document.)

Q. Do you recall just generally that you were asked about the phrase "business decision"?

A. Yes.

Q. In your experience, is the evidence base that supports a guideline always clear?

A. Yes. I'm sorry. What was the question again?

Q. Okay. In your experience --

A. Yes.

Q. -- is the evidence base that supports a guideline always clear?

A. No.

Q. Are there instances that you can recall when UBH had to make a decision regarding guideline changes without evidence base?

A. Yes.

Q. And in those situations, what would UBH look to to support the guideline change?

A. So in that particular example, it cited myself and Dr. Bonfield, and that was a clinical decision based on our clinical judgment and our clinical expertise.

Q. But it said "business decision." So what did you mean by "business decision" when you said that?

A. I'm not sure why that word was in there, that document, but I remember the discussion and the discussion was very much a clinical one.

MR. RUTHERFORD: One moment, Your Honor. I think I may be done.

THE COURT: Okay.

(Pause in proceedings.)

BY MR. RUTHERFORD:

Q. And then you were asked questions, do you recall -- I guess directing your attention to Exhibit 517, and specifically to the two pieces of critical feedback that were read into the record. Do you recall that, Dr. Triana?

A. Hold on one second.

(Witness examines document.) Yes, 517.

Q. And the last sentence of that first piece of critical feedback read (reading):

"Peer reviewers often use these guidelines as a cookbook and do not use clinical judgment."

Do you see that?

A. Yes.

Q. Do you agree that UBH's medical directors should use clinical judgment in making coverage determinations?

A. Yes.

MR. RUTHERFORD: No further questions, Your Honor.

MR. KRAVITZ: Your Honor, one more document. It will take a minute.

RECROSS-EXAMINATION

BY MR. KRAVITZ:

Q. If you could open your book to 552, please.

A. (Witness examines document.)

Q. And those are minutes of the Utilization Management

Committee dated August 9, 2016; is that correct?

A. Yes, sir.

Q. And if you turn to page 0006, do you see that?

A. Yes.

Q. There's something on the quick cert treatment milestones update.

MR. RUTHERFORD: Objection, Your Honor. Beyond the scope.

THE COURT: Sustained.

Thank you very much.

MR. KRAVITZ: I just was -- okay.

THE COURT: Okay. You may step down.

THE WITNESS: Oh. Thank you.

THE COURT: Thank you.

(Witness excused.)

MR. RUTHERFORD: Your Honor, by video the defense now calls John Beaty.

THE COURT: How long?

MR. RUTHERFORD: It's a ten-minute video.

THE COURT: Okay. What time is it?

THE CLERK: 3:28.

THE COURT: Okay. Let's get going. Sure.

MR. RUTHERFORD: Right now, Your Honor?

THE COURT: Yeah, if everybody's okay.

MR. RUTHERFORD: May I just walk the witness out while

they --

THE COURT: Yes. That's fine.

(Pause in proceedings.)

(Video was played but not reported.)

MS. ROSS: Your Honor, we move to admit Exhibits 1011 and 1012.

MR. ABELSON: No objection.

THE COURT: They're admitted.

(Trial Exhibits 1011 and 1012 received in evidence)

MS. ROSS: Your Honor, we do have one more witness we'd like to call this afternoon. UBH calls Dr. Thomas Goddard.

THE COURT: Okay. Well, we can do 15, 20 minutes of Dr. Goddard.

MS. ROSS: We think we might be able to complete his direct examination in that time.

(Pause in proceedings.)

THOMAS GLENN GODDARD,

called as a witness for the Defendant, having been duly sworn, testified as follows:

THE WITNESS: I do.

THE CLERK: Thank you. Go ahead and have a seat.

Please state your full name for the record and spell your last name.

THE WITNESS: Thomas Glenn Goddard, G-O-D-D-A-R-D.

THE CLERK: Thank you.

THE COURT: Okay. Proceed.

DIRECT EXAMINATION

BY MR. BUALAT:

Q. Good afternoon, Dr. Goddard.

A. Good afternoon.

Q. Can you please briefly explain -- excuse me -- describe your educational background after high school?

A. I attended the University of Arizona in 1972 to 1976, received a bachelor's in political science. I went to law school, received my Juris Doctor from the University of Arizona in 1979. Went back to graduate school in '92 and -- in George Mason University, got a master's in industrial organizational psychology and a Ph.D. in industrial organizational psychology.

Q. And what has been the focus of your career over the last 20-plus years?

A. I've been in healthcare for about that length of time and for the last 18 or so years, focusing on accreditation of healthcare organizations.

Q. And what is the accreditation of healthcare organizations?

A. It's a process by which an independent body assesses whether a healthcare organization meets certain national standards for process. It depends on the accreditation as to what process.

Q. And you're currently employed in that field?

A. I am.

Q. And who's your current employer?

A. Integral Healthcare Solutions.

Q. And what is your role there?

A. I'm the founder and chief executive officer of that firm.

Q. And when did you found Integral Healthcare Solutions?

A. January of 2002. So about 15 and a half years ago.

Q. And what does Integral Healthcare Solutions do?

A. We specialize in helping healthcare organizations achieve accreditation from certain accreditation -- no -- yeah, healthcare organizations achieve from about a half a dozen different accreditation bodies.

Q. And what type of accreditation support services does your company provide?

A. The bulk of our work is documentary assessment. We review through a GAAP analysis and desktop review process documents to be submitted for accreditation to accreditation organizations.

We also conduct mock on-site reviews as well as a part of that preparation, and other things as well: Preparing policies, procedures, and helping our clients in all sorts of ways, but mainly this document assessment takes most of our time.

Q. And prior to founding your company, did you work with any of the accrediting agencies?

A. Yes. I worked with URAC.

Q. And what was your role at URAC?

A. I was chief operating officer and general counsel at URAC and also both as an employee, and after that I was a reviewer for URAC.

Q. Approximately how many healthcare utilization management accreditation processes have you worked on in your career?

A. I've been involved with organizations dealing with health UM, health utilization management, probably 200 times. Maybe 175 to 200.

Q. And have you done any training or teaching with respect to healthcare utilization management before?

A. I have.

Q. How about the accreditation process?

A. Very much so, yes.

Q. What is your opinion that you plan to offer today at trial?

A. I reviewed nearly 200 documents from UBH; and based on a review of those documents, I've concluded that UBH met the requirements of UM 2 of the NCQA standards and HUM 1 of the URAC standards dealing with the selection and approval of clinical review criteria.

Q. And you said you reviewed UBH internal documents; is that right?

A. I did.

Q. What types of documents did you review in reaching your

opinion today?

A. The typical set of documents that accreditation organizations review in connection particularly with those particular standards I mentioned. So examples would be utilization management program descriptions and other policies and procedures; committee and task force meeting minutes; lists of providers whose opinion were solicited in the selection, review, and approval of those clinical review criteria; the clinical review criteria themselves.

Q. You mentioned clinical review criteria. Would that include any Level of Care Guidelines, Coverage Determination Guidelines? What were you referring to?

A. Level of Care Guidelines for the most part that were the focus of my review.

Q. And why is that document -- why are those documents relevant to your understanding of utilization management?

A. Well, those are the documents that help an organization to demonstrate to the accreditation organization that they've met the specific criteria of those standards I referenced.

Q. Now, you mentioned a few organizations. What are the organizations that accredit healthcare utilization management organizations?

A. The ones that I've -- my organization focuses on are URAC and NCQA.

Q. Are there other ones that also involve an accreditation?

A. Not at the same level as those two organizations.

Q. And what is your view about the accreditations from either of those organizations?

A. What is my view of them?

Q. Yes.

A. Well, they dominate the field. For major health plans and for freestanding health utilization management organizations, those two are the gold standard.

Q. And what is the purpose in your mind of healthcare utilization management accreditation?

A. They are a demonstration to payers, regulators, and consumers that the organization that has been accredited under those standards has complied with these national standards for process around those particular topics.

Q. Let's focus on URAC. What is the focus of URAC?

A. URAC from its inception focused on utilization review. In fact, the "UR" in the original name was the Utilization Review Accreditation Commission. So that's been its central focus, and it continues to be a very important focus for health plans, utilization management organizations. And you can see that influence in some other kinds of accreditation programs to pharmacy benefit management accreditation all have these utilization review standards or something like them in them.

Q. Who governs URAC?

A. URAC is governed by a large and diverse Board of

Directors. The members of that Board of Directors are drawn from stakeholders across the healthcare industry from providers like the American Medical Association, American Hospital Association; payers like America's health insurance plans, the Blue Cross/Blue Shield association; regulators like the NAIC, the insurance regulators; consumer organizations are represented and other stakeholders throughout the healthcare industry.

Q. Do any of those stakeholders include any behavioral health-related organizations?

A. Yes.

Q. Which ones?

A. I believe the American Psychiatric Association.

Q. Do you have an understanding as to why URAC has those variety of stakeholders on its board?

A. It helps with the credibility of standards. If you can develop accreditation standards that all of the major stakeholders in your industry -- in this case healthcare industry -- or most of them agree on, then the credibility of the standards is raised.

Q. And you also mentioned an organization called NCQA. Do you remember that?

A. Yes.

Q. What is the NCQA?

A. National Council of Quality Assurance.

Q. And how does NCQA compare relatively as far as its role to URAC?

A. It was created around the same time, 1989 or 1990. Its focus was different than URAC. Where URAC was focused on the utilization review process, NCQA was focused in its inception on health plans, which include the utilization review process, but -- and more HMO-style health plans at first.

In both cases URAC and NCQA have broadened the scope of accreditation programs that they operate in, but the initial focus and to this day is still on health plans.

Q. As part of the accreditation process, is the development of clinical guidelines for healthcare utilization management reviewed?

A. Yes.

Q. And the accreditation process that URAC and NCQA, is that similar with respect to the development of clinical guidelines?

A. Yes.

Q. And can you briefly describe what that process entails?

A. The two standards from NCQA and URAC have essentially the same requirements, and they require that you have actively practicing providers with relevant knowledge in the field who are consulted, that evidence-based or literature-based considerations are taken into account, and that the guidelines be reviewed annually to make sure that they're up to date.

Q. And how would you characterize the time and effort that

goes into the process for accreditation?

A. It's substantial, particularly for the kinds of organizations we're talking about, large, complex organizations.

Q. Are there standards for accreditation with respect to developing guidelines that are viewed as the national standards?

A. Yes. These two organizations' accreditation standards on this topic are national -- the national standards for the development and review and approval of clinical review criteria.

Q. All right. Let's look at one of those standards. Can you please pull up Exhibit 1012, and if you could turn to page 0154, and let's focus on the top half of that page, please.

A. (Witness examines document.)

Q. So, Dr. Goddard, are you familiar with this provision that is displaying on your screen there?

A. Yes.

Q. Actually, if you could blow it up, please.

What is it?

A. This is taken from Version 7.0 of the Health -- of the URAC Health Utilization Management Accreditation Program, and it's HUM 1, which is the standard that describes URAC's requirements for the clinical review criteria selection

development, et cetera.

Q. Now, did you make any conclusions about UBH and its compliance with or satisfaction of UH 1 [sic] in your work?

A. Yes. Based on the documents I reviewed, UBH met and/or exceeded these requirements of each of these elements.

Q. Okay. Let's look first at requirement under subsection (a). It says that the clinical review criteria or scripts are developed with involvement from appropriate providers with current knowledge relevant to the criteria or script under review. Do you see that?

A. I do.

Q. And did UBH meet or exceed that requirement?

A. In my opinion, yes.

Q. The next requirement under subsection (b) says that the criteria is based on current clinical principles and processes. Do you see that?

A. Yes.

Q. And did UBH meet or exceed that requirement?

A. Yes.

Q. And what is your -- and why do you say that?

A. The documentation I reviewed, particularly the task force meeting minutes, e-mails in connection with task force meetings, and the guidelines themselves, the Level of Care Guidelines, all showed abundant evidence of this.

Q. The criteria Number C under HUM 1, it says (reading):

"Evaluated at least annually and updated if necessary by, one, the organization itself; and, two, appropriate actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts under review."

Do you see that?

A. I do.

Q. And did UBH meet or exceed that requirement?

A. Yes.

Q. And what do you base your determination on?

A. Well, let's take the annually first. I looked at documentation from each of the years in question, 2008 through 2016, and I saw ongoing annual processes. So that criterion was met.

And then the organization itself involving appropriately -- appropriate actively practicing physicians, the documentation throughout that period of time involved -- involved both providers from within the organization and from outside of the organization engaged in a rather dynamic process of review and development of clinical review criteria.

Q. Do you know why URAC requires that actively practicing providers provide input as to the criteria under review?

A. I believe it's URAC's way of making sure that the review criteria are based on current principles.

Q. Under URAC HUM 1, is it necessary for an organization to

seek input from experts from outside the organization?

A. It is not.

Q. Is it -- when would be an instance in which the organization would need to seek outside input?

A. If the pool of providers that they have within the organization don't meet the criteria of this standard.

Q. And did UBH's internal pool meet the criteria for the standard?

A. Yes.

Q. Then was it necessary for UBH to seek external input -- excuse me -- external input?

A. It was not.

Q. And how were you able to determine that UBH sought external output -- input?

A. They -- through a couple of ways. On a number -- a number of documents had actual lists of outside providers with their qualifications of providers who were solicited for their input, and the task force meeting minutes also reflected input from outside providers.

Q. All right. Let's look at the last criteria under HUM 1. Subsection (d) says (reading):

> "Approved by the medical director or equivalent designate or clinical director or equivalent designee."

Do you see that?

A. I do.

Q. Did UBH satisfy that requirement?

A. Yes.

THE COURT: So before you do that, can I ask a question about subsection (b)?

THE WITNESS: Yes.

THE COURT: Is that a process or a substantive criteria?

THE WITNESS: It's process.

THE COURT: And what process is it that it represents?

THE WITNESS: It represents typically a task force or committee looking at and debating or discussing whether, you know, this clinical procedure is appropriate or whether there's been research elsewhere or clinical practice that has come to light that would suggest it should be changed.

THE COURT: Thank you.

THE WITNESS: You're welcome.

BY MR. BUALAT:

Q. If we could move on, let's go to Exhibit 1011 and page 007 of that, please. And focusing on the top half of that page through element (a), item (5), please.

Dr. Goddard, are you familiar with what's displayed on your screen there?

A. I am.

Q. And what is that?

A. This is URAC's equivalent to the standard we just looked

at from -- this is NCQA's equivalent to the URAC standard we just looked at.

Q. And are these criteria similar in nature to the URAC criteria we just looked at?

A. Very similar, particularly under element (a), numbers (1), (4), and (5).

Q. And are those the elements that relate to the development of clinical guidelines?

A. Yes.

Q. Do you have an opinion as to whether or not UBH satisfied those elements that you identified?

A. I do, and that opinion is that they did.

Q. So do you have an opinion as to whether or not UBH has written decision-making criteria that are objective and based on clinical evidence?

A. Yes, and I believe they -- my opinion is that they did.

Q. And do you have an opinion as to whether or not UBH involves appropriate practitioners in developing, adopting, and reviewing criteria?

A. Yes. UBH in my opinion does.

Q. And, finally, do you have an opinion as to whether or not UBH annually reviews the UM criteria and the procedure for -- excuse me -- procedures for applying them and updates the criteria when appropriate?

A. I do, and UBH does meet that element.

Q. Does URAC review and accredit the substantive content of clinical guidelines?

A. No.

Q. Does NCQA review and accredit the substantive content of clinical guidelines?

A. No.

Q. Do these national standards that we've been looking at require a utilization management organization to adopt particular guidelines?

A. No.

Q. How about require that guidelines that are adopted follow some format or structure?

A. No.

Q. Does it require that the guidelines use some kind of algorithm?

A. No.

Q. How about if it has some decision tree relating to level-of-care decisions, is that a requirement?

A. No.

Q. Based on your review of UBH's accreditation documents, were you able to assess how UBH develops its clinical guidelines?

A. Yes.

Q. And how is that?

A. It has a task force composed of diverse clinicians from

within the organization. That task force leads the process and is supported by staff, nonvoting members of the task force, who provide technical support and organizational support. The task force oversees a process by which providers within the organization and outside of the organization are solicited for their opinion on the clinical review criteria. There's debate and discussion and drafting of new criteria each year.

Q. And how would you describe the level of detail in UBH's guideline creation?

A. Robust.

Q. And based on your experience, do you have an opinion as to what the best practices are for a utilization management organization in the development of clinical guidelines?

A. I do.

Q. And did UBH employ best practices in developing its clinical guidelines?

A. In my opinion, it did.

MR. BUALAT: I pass the witness, Your Honor.

THE COURT: Okay. So do you have any cross-examination of this witness?

MR. ABELSON: I do. More than 10 or 15 minutes.

THE COURT: No, I can't do 10 or 15 minutes. Two minutes I can do.

MR. ABELSON: I'd be happy to start.

THE COURT: No. You're going to have to go over to

tomorrow. We're going to stop now.

So I apologize for this --

THE WITNESS: No problem at all, sir.

THE COURT: -- but I have to stop at 4:00.

So where are we?

MS. ROMANO: We expect to conclude our case before lunch tomorrow, Your Honor.

THE COURT: Okay. And then?

MS. REYNOLDS: We may have a very brief rebuttal case.

THE COURT: Okay. Great. And then we'll do closings on Wednesday? Is that okay?

MS. REYNOLDS: That's the plan.

MS. ROMANO: That's the plan.

THE COURT: I have 9:30 calendar, so 10:30 for closings on Wednesday.

MS. REYNOLDS: Okay.

THE COURT: Perfect. Thank you.

MS. REYNOLDS: Thank you.

MS. ROMANO: Thank you.

(Proceedings adjourned at 4:00 p.m.)

(Proceedings to resume on Tuesday, October 31, 2017.)

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CERTIFICATE OF REPORTERS

We certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

DATE: Monday, October 30, 2017

Katherine Powell Sullivan, CSR #5812, RMR, CRR
U.S. Court Reporter

Jo Ann Bryce, CSR #3321, RMR, CRR
U.S. Court Reporter